THE CHRONIC PELVIC PAIN CENTER OF NORTHERN VIRGINIA

8100 Boone Blvd |Suite 710 |Tysons Corner |VA 22182 | Phone: 703.448.6070

https://www.gynwellnesscenter.com

Welcome to the Chronic Pelvic Pain Center of Northern Virginia:

We would like to take this opportunity to welcome you to our practice and to thank you for choosing our healthcare providers to participate in your healthcare. We look forward to meeting you and getting acquainted to provide you with personalized, comprehensive health care focusing on wellness and prevention. As continuity and coordination of patient care is essential in meeting your healthcare needs, our healthcare team work closely in a "team approach" to support your patient care.

We have included information regarding our office protocol regarding appointments, cancellation, insurance billing, payment policy, other pertinent information, which answers to some of the most commonly asked questions by prospective patients entering our practice. We hope you will find this information useful.

Enclosed is a Patient Registration and Medical History forms. We ask you to complete them for your appointment to expedite your registration process. If we can be of further assistance before your visit, please give us a call at (703) 448-6070.

Sincerely,

Melissa A. Delgado, MD, FACOG

Wendy Roberts, CANP

Amanda McClay, CNM, WHNP

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OFFICE POLICIES AND PROCEDURES FOR PATIENTS

APPOINTMENTS, CANCELLATIONS, AND NO-SHOW POLICY

The Chronic Pelvic Pain Center of Northern Virginia (CPPC) is committed to providing quality care to our patients. To ensure timely continued care, we encourage patients to schedule appointments in advance of follow-up due dates. When calling for an appointment, please provide your name, telephone number, chief complaint/reason for visit, as well as any *updated contact or insurance information.*

Please arrive on time for your scheduled appointments. New patients should plan to arrive 15-30 minutes early to allow for completing forms and updating your electronic medical record in the computer. If you are more than 15 minutes late, we may have to reschedule your appointment.

We utilize an automatic calling system that will call you 48 hours in advance of your appointment. We do understand that in today's busy world occasionally situations come up that are beyond your control. In those instances, we do request you extend us the courtesy of a 24-hour notice for regular patient appointments and 48-hour notice for Chronic Pelvic Pain appointments. Failure to present at the time of a scheduled appointment will be recorded in your medical chart as a "no show" and a fee of $50 will be billed to your account for regular appointments, which will have to be paid before or at your next scheduled appointment. Please be advised, due to the high demand for scheduling Chronic Pelvic Pain appointments, effective immediately our office will charge a fee of $250.00 for no-show, cancellation or rescheduling. A 48-hour notice is needed to cancel or reschedule this type of appointment.

No-Show charges are patient responsibility and will not be billed to your insurance company. This courtesy allows us to continue to operate efficiently and use the time that was reserved for you to help other patients in need.

While we strive to schedule appointments appropriately, emergencies can and do occur in health care. For this reason, we kindly request your patience and understanding should a delay or rescheduling become necessary on your appointment date, we do our best to keep our patients up-to-date of any changes to their scheduled appointments promptly.

OFFICE CLOSINGS DUE TO WEATHER OR OTHER CIRCUMSTANCES

If our office is closed due to weather conditions or other circumstances beyond our control, the following procedures are used to inform our patients:

- If you are scheduled for an appointment, you will receive an automated message by telephone.

INSURANCE

- CPPC accepts most insurance plans. If you have specific questions regarding your insurance, please contact our office at (703) 448-6070 during business hours.
- It is patient responsibility to inform our office of any changes in insurance coverage. Failure to do so could cause delay or denial of insurance payment.
- All patients will be asked to present their current insurance card at each appointment. Failure to have your card could delay your appointment, and it will be the responsibility of the patient to provide proof of coverage.

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OFFICE POLICIES AND PROCEDURES FOR PATIENTS

PAYMENTS

- Patients are responsible for co-pays at *time of service.* If applicable, you will be billed for services not covered by your insurance (as stated in your insurance contract) by our billing department.
- CPPC accepts cash, personal checks, MasterCard, Discover, Visa and American Express.
- Non-Insured Patients:
  - Payment in full is due at the time of service. If you are unable to pay your balance in full, you will need to make arrangements with our Office Manager.
- Medicare Patients:
  - You are personally responsible for your deductible, co-insurance and any services that Medicare deems as "Medically Unnecessary". Medicare patients may also be asked to sign an Advanced Beneficiary Notice (ABN) form as required by Medicare for certain services.
- Returned Checks:
  - A $35 fee will be assessed for any check returned for insufficient funds. After that, only cash or credit cards will be accepted for payment.

It is the policy of CPPC to make all reasonable attempts to collect outstanding balances should they accrue, including, convenient payment arrangements. Following these attempts, accounts in poor standing will be outsourced to a third party for the purpose of collection.

CONFIDENTIALITY & MEDICAL RECORDS

Per HIPAA guidelines, copies of medical records must be requested in writing. To ensure your privacy, a form for release of medical information must be completed prior to receipt of these materials. There may be times when you may request that we provide copies of your medical records to you or other entities. We do incur an expense to provide you with this service and that cost will be passed on to you. Our fee for copies is $10 that includes copying up to 10 pages. There is a $0.50 charge for each additional page plus postage cost.

PRESCRIPTION REFILLS & PHARMACY INFORMATION

- Please inform CPPC of which Pharmacy you use and update us if this should change. Please allow two to three business days for refill requests.
- Please evaluate your medication supply prior to your office visits and try to correlate all refills with your scheduled appointments. Should refills be requested after a visit they will only be authorized if the physician determines there is an extenuating circumstance warranting a refill outside of the timeframe of a scheduled office visit.
- When you call please have the following information ready: patient name and date of birth; prescription name and number; pharmacy name and telephone number. Please check at the pharmacy after 48 hours-do not recall our office. We will only call you back if there is a problem with refilling your request.
- Please note that we do not fill Narcotic Medications or order Antibiotics over the phone.
- Our Practice does not routinely order Narcotic Pain Medicine; therefore, you may be required to obtain these medications through a Pain Management specialist.

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OFFICE POLICIES AND PROCEDURES FOR PATIENTS

COMPLETION OF FORMS AND LETTERS

We understand that at times, various forms or letters may be required to assist you with your healthcare needs. The staff at CPPC will be happy to complete forms and write medical letters as necessary upon your request for a fee. However, because this can be time consuming, please allow 7-10 days for completion of requested forms and or letters. All fees will have to be paid before completed forms are released.

Fee Schedule for Disability Forms

- Short Term Disability paperwork---------$40.00
- Long Term Disability paperwork----------$80.00

OUR PATIENT PORTAL

As a means of ensuring timely communication with our patients, we strongly encourage you to sign up for the **Patient Portal**, which can provide a quick and easy method for scheduling appointments, entering and updating medications, etc. As a new patient, you will receive instructions on how to sign up for the Patient Portal. If you have questions or need assistance, please feel free to speak with a member of our reception team.

ADDITIONAL INFORMATION

If you have further questions or need additional information about our services, please feel free to call our office at (703) 448-6070 and or visit our website at www.gynwellnesscenter.com

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OFFICE POLICIES AND PROCEDURES FOR PATIENTS

RECEIPT ACKNOWLEDGMENT FORM

By signing below, I acknowledge that I have received, reviewed, understand, and will comply with the policies and procedures explained in the Chronic Pelvic Pain Center of Northern Virginia OFFICE POLICIES & PROCEDURES FOR PATIENTS form.

PRINT NAME

SIGNATURE

DATE

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PATIENT DEMOGRAPHICS

Last Name	First Name	Middle Initial	Date of Birth	Age	Gender
					☐ M ☐ F

Social Security Number	Status	Student
	☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Partner ☐ Widowed	☐ No ☐ Full-Time ☐ Part-Time

Address	City	State	Zip Code

Occupation	Home Phone *(include area code)*	Work Phone *(include area code)*	Cell Phone *(include area code)*

Employment Status	Preferred Pharmacy & Location *(City & State)*	Pharmacy Phone *(include area code)*
☐ Full-Time ☐ Part-Time ☐ Unemployed ☐ Self-Employed ☐ Retired ☐ Active Military		

Employer's Name	Employer's Address	Race	Preferred Language
		☐ Asian ☐ Native Amer. Indian /Alaska Native ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ Caucasian/White ☐ Other ☐ Hispanic ☐ Declined	☐ English ☐ Spanish ☐ Other:
Email Address			

Primary Care Physician	Address	City	State	Zip Code

Emergency Contact's Name	Relationship to Patient	Home Phone	Work/Cell Phone
	☐ Spouse ☐ Parent ☐ Guardian ☐ Other_____		

Emergency Contact's Address	City	State	Zip Code	Do you have Living Will?
				☐ Yes ☐ No

GUARANTOR OR RESPONSIBLE PARTY (IF THIS SECTION IS LEFT BLANK, PATIENT WILL BE THE ASSUMED RESPONSIBLE/BILLED PARTY)

Last Name	First Name	Middle Initial	Date of Birth	Relationship to Patient
				☐ Self ☐ Spouse ☐ Parent ☐ Guardian

Address	City	State	Zip Code	Gender	Date of Birth
				☐ M ☐ F	

Social Security Number	Home Phone	Work Phone	Cell Phone

Employer Name and Address	Employer Phone

BILLING AND HEALTH INSURANCE INFORMATION

PRIMARY INSURANCE

Insurance Company Name	ID or Policy Number	Group Number	Effective Date

Insurance Company Claims Address	City	State	Insurance Company's Phone

Insured/Policyholder's Name	Gender	Policyholder's Social Security Number	Policyholder's Date of Birth
	☐ M ☐ F		

Insured/Policyholder's Address	City	Relationship to Patient

SECONDARY INSURANCE

Insurance Company Name	ID or Policy Number	Group Number	Effective Date

Insurance Company Claims Address	City	State	Insurance Company's Phone

Insured/Policyholder's Name	Gender	Policyholder's Social Security Number	Policyholder's Date of Birth
	☐ M ☐ F		

Insured/Policyholder's Address	City	State	Relationship to Patient

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PATIENT DEMOGRAPHICS

UNIVERSAL CONSENT - THE CHRONIC PELVIC PAIN CENTER OF NORTHERN VIRGINIA

PATIENT NAME: _____ DATE OF BIRTH: _____ DATE: _____

CONSENT FOR TREATMENT _____ (Please Initial)
I hereby consent to the administration and performance of all tests and treatments by members of the medical staff and personnel of The Chronic Pelvic Pain Center of Northern Virginia (CPPC) which, in the judgment of the physician(s) and/or nurse practitioner(s), may be considered necessary or advisable for the diagnosis or treatment for the condition for which I am presenting myself. I understand that the practice of medicine and surgery is not an exact science and acknowledge that no guarantees have been made to me. I authorize CPPC to request and receive information, including my medical record, from my treating physician(s), nurse practitioner(s) or agents. I also authorize CPPC to test my blood for hepatitis and/or the AIDS virus, if in their opinion; an employee has suffered an exposure incident as a result of my treatment, as defined by the Occupational Safety and Health Administration.

NOTICE OF DEEMED CONSENT FOR HIV, HEPATITIS B OR C TESTING _____ (Please Initial)
CPPC is required by *§ 32.1-45.1 of the Code of Virginia (1950),* as amended, to give you the following notice:

1. If any CPPC health care professional, worker or employee should be directly exposed to your blood or body fluids in a way that may transmit disease, your blood will be tested for infection with human immunodeficiency virus (the "AIDS" virus), as well as for Hepatitis B and C. A physician or other health care provider will tell you the result of the test. Under Va. Code § 32.1- 45.1(A), you are deemed to have consented to the release of the test results to the person exposed.
2. If you should be directly exposed to blood or body fluids of a CPPC health care professional or staff in a way that may transmit disease, that person's blood will be tested for infection with human immunodeficiency virus (the "AIDS" virus), as well as for Hepatitis B and C. A physician or other health care provider will tell you and that person the result of the test.

I understand that this consent will remain in effect as long as my dependent or I receive care from CPPC or until I withdraw it.

PAYMENT AND ASSIGNMENT OF INSURANCE BENEFITS _____ (Please Initial)
I will reimburse the charges from CPPC, my treating physician(s) and/or nurse practitioner(s) for medical care provided to me either through my insurance coverage or directly. In consideration of those services, I hereby assign, transfer and convey to CPPC, my treating physician(s) and/or nurse practitioner(s), all of my rights, title and interest in my medical insurance for medical expense reimbursement, including, but not limited to adding dependent eligibility, and to have a policy continued or issued in accordance with the terms of benefits under any insurance policy continued or issued. If my medical insurance coverage is not sufficient to satisfy such costs, charges and expenses in full, or I do not follow guidelines of my insurer and the resulting balance is not covered by the Assignment of Insurance benefits, I will be fully responsible for payment of the balance.

I hereby consent to the release and re-disclosure of my medical record to enable or facilitate the collection, verification or settlement of my account for any amounts due from me or any third-party payer, health maintenance organization, insurer or other health benefit plan. I understand it is my responsibility to understand my insurance coverage for my medical visit. If my visit is for a wellness benefit, I will advise my physician(s) and/or nurse practitioner(s) at the time of my visit. (Labs will be ordered with an associated diagnosis in my medical record which may impact reimbursement.) This consent applies to CPPC, or any of its affiliates or agents, lenders, or any third-party servicer acting on behalf of CPPC.

MISSED APPOINTMENTS _____ (Please Initial)
Cancellation of an appointment with less than 24 hours' notice or any appointment missed without prior notification may be subject to a $50 cancellation charge. After three missed appointments, the scheduling of future appointments will be at the discretion of the practice.

RECEIPT OF NOTICE OF PRIVACY PRACTICES _____ (Please Initial)
I acknowledge that I have received CPPC's Notice of Privacy Practices. I understand that the notice describes the uses and disclosures of my protected health information by CPPC and informs me of my rights with respect to my protected health information. For more information, please contact the Patient Advocate Office at (703) 448-6070.

I have read this form, or had it read to me, and I certify that I fully understand and accept its contents unless noted.

_____	_____	_____
PATIENT'S SIGNATURE	PATIENT'S NAME (PLEASE PRINT)	DATE
_____	_____	_____
PARENT/LEGAL GUARDIAN SIGNATURE	PERSON GIVING CONSENT AND RELATIONSHIP TO PATIENT	WITNESS - CPPC EMPLOYEE

The Patient, _____, is a minor, or is unable to sign above because: _____
(NAME PRINTED)

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NEW PATIENT MEDICAL HISTORY

Please complete this form accurately and bring it with you to your first appointment. All information provided will be kept confidential and not divulged to anyone without your request or permission.

CHIEF COMPLAINTS: Today's Date: _____ Appointment Date: _____

Name: _____ DOB: _____ Age: _____

Referring Provider: _____ PCP: _____

Allergies: _____ Height: _____ Weight: _____

Do you smoke? ☐ Yes ☐ No Do you drink Alcohol? ☐ Yes ☐ No If Yes, how often? _____

Please provide dates where applicable.

Last date of Menstrual cycle: _____ Last Annual exam: _____

Last date of Pap Smear: _____ ☐ Normal ☐ Abnormal

Last date of Mammogram: _____ ☐ Normal ☐ Abnormal

Last date of Colonoscopy: _____ ☐ Normal ☐ Abnormal

Last date of Bone Density Exam: _____ ☐ Normal ☐ Abnormal

Do you have or have ever had any of the following:

☐ Anemia	☐ Chronic Pelvic pain	☐ Heart disease	☐ Liver disease
☐ Asthma/Lung disease	☐ Deep Vein Thrombosis	☐ **Hepatitis** ☐A ☐B ☐C	☐ Mental Illness
☐ Back problems	☐ Depression	☐ Herpes	☐ Migraines
☐ Bleeding disorder	☐ **Diabetes** ☐ 1 ☐ 2	☐ High Blood Pressure	☐ Osteopenia
☐ Blood transfusion	☐ Diarrhea	☐ High Cholesterol	☐ Osteoporosis
☐ Bowel problems	☐ Endometriosis	☐ HIV	☐ Pelvic pain
☐ Breast disease	☐ Fibroids	☐ HPV/Genital warts	☐ Seizures
☐ **Cancer-List type(s) below:**	☐ Fibromyalgia	☐ Hyperthyroidism	☐ Sexual abuse/assault
1. _____	☐ Gallbladder disease	☐ Hypothyroidism	☐ Sleep Apnea
2. _____	☐ Gene Mutations (MTHFR	☐ IBS	☐ Skin problems
3. _____	Factor V Leiden)	☐ Infertility	☐ STD
☐ Constipation	☐ Gestational Diabetes	☐ Interstitial cystitis	☐ Substance abuse

MENSTRUAL HISTORY

Age when period begun: _____

No. of days in cycle: _____ Cramping? ☐ Yes ☐ No

Menstrual flow: ☐ Normal ☐ Light ☐ Moderate ☐ Heavy

Method of contraception: _____

Menopause? ☐Yes ☐No Date of last period: _____

Are you on Hormone Replacement Therapy? ☐ Yes ☐ No

PREGNANCY HISTORY

No. of full-term births _____

No. of pre-term births _____

No. of vaginal deliveries _____

No. of miscarriages _____

No. of C-sections _____

No. of living children _____

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NEW PATIENT MEDICAL HISTORY

CURRENT MEDICATION HISTORY

	MEDICATION	DOSAGE (MG; MCG; ML)	FREQUENCY	PRESCRIBING PHYSICIAN
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

PAST SURGERIES

☐ No past surgical history

YEAR	TYPE OF SURGERY	COMPLICATIONS
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

FAMILY HISTORY: PLEASE PLACE A CHECK MARK (✓) WHERE APPLICABLE

DISEASE	NONE	MOTHER	FATHER	BROTHER	SISTER	MATERNAL GRANDMOTHER	MATERNAL GRANDFATHER	PATERNAL GRANDMOTHER	PATERNAL GRANDFATHER	AUNT	UNCLE
Ovarian cancer											
Uterine cancer											
Cervical cancer											
Breast cancer											
Bowel cancer											
Heart disease											
Mental illness											
Thyroid problems											
Diabetes											
High blood pressure											
Kidney disease											
Interstitial cystitis											
Chronic pelvic pain											
DVT/Blood clots											

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NEW PATIENT MEDICAL HISTORY

AUTHORIZATION AND RELEASE:

I hereby certify that I have completed the above information to the best of my knowledge. I authorize, consent, request, and agree to actively participate in such services as routine assessments, the performance of diagnostic tests and procedures, care and treatment as self-referred or as ordered by my physician, his/her assistant or designees.

SIGNATURE _____ DATE _____

Please fax (703.448.9292) your completed form to our office prior to your appointment. If you cannot return your form prior to your appointment, you must **arrive 30 minutes early** so we can enter your information into the computer. This information needs to be entered prior to you seeing a provider.

Thank you for your attention and cooperation.

The Staff at the Chronic Pelvic Pain Center of Northern Virginia
Office of Melissa A. Delgado, MD, FACOG