IMPORTANT! PLEASE READ!

Thank you for choosing **Women's Healthcare Associates of Redding** for your health care needs.

This paperwork must be completed and returned to our office prior to scheduling your initial appointment.

If you have an appointment scheduled, you are required to return this paperwork at LEAST 5 DAYS PRIOR TO YOUR APPOINTMENT.

This office uses an electronic health record. Your chart does not exist until we receive this registration paperwork from you and we enter the written information into your health record.

We offer several options such as **mailing, faxing, emailing or competing paperwork online** that will assist you to return your paperwork in a timely manner.

Our PHONE number is: (530) 246-4455
Our FAX number is: (530) 229-1159
Our MAILING address is: 2420 Sonoma St., Ste. B, Redding CA 96001
Our EMAIL address is: reception@dr4women.com

It is important that each section be filled out. For example, if you are unsure about a question or it doesn't apply to you, please write Unsure, N/A or draw a line through it. By doing this we know you have read the questions and we can avoid the delay of having to call you to seek additional information.

PLEASE BRING A LIST OF YOUR MEDICATIONS AND/OR SUPPLEMENTS WITH YOU TO YOUR FIRST APPOINTMENT.

ALSO, PLEASE COME PREPARED TO LEAVE URINE SAMPLE.

Thank you again for completing and returning your paperwork right away. We look forward to your first visit.

WOMEN'S HEALTHCARE ASSOCIATES OF REDDING

PATIENT REGISTRATION INFORMATION

Patient Name_____ Date of Birth_____ S.S. #_____

Mailing Address_____

City, State, and Zip Code_____

Home Phone#_____ Cell Phone#_____Work Phone_____

What is your e-mail address? _____

Is your marital status married, single, divorced, separated, widowed, other? _____

Race/Nationality: (such as Caucasian/African American/Hispanic/ Asian American/ Indian, or other)
_____

Language_____Occupation_____How did you hear about us? _____

PREFERRED PHARMACY_____

PREFERRED LABORATORY_____

**** By Initialing here_____, you give Women's Healthcare Associates of Redding permission to leave messages on your home/cell phone voicemail; including test results, appointments or clinical information.**

****By initialing here_____, I agree to receive automated calls.**

****By initialing here_____, I acknowledge that I have received a copy of Women's Healthcare Associates of Redding Office Policies.**

Patient / Parent / Guardian (PLEASE PRINT PATIENT NAME)

SIGNATURE **DATE**

INSURANCE AND BILLING INFORMATION

PRIMARY

INSURANCE COMPANY_____

NAME OF INSURED_____

ID#_____**GROUP#**_____

SECONDARY

INSURANCE COMPANY_____

NAME OF INSURED_____

ID#_____**GROUP#**_____

ASSIGNMENT OF INSURANCE INFORMATION

*I hereby authorize direct payment of medical/surgical benefits to Women's Healthcare Associates of Redding for services rendered.

*I understand that depending on my insurance that I may require an ERAF before being seen and it is my responsibility to get it from my primary before being seen.

*I understand that I am financially responsible for all charges incurred whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection and reasonable attorney's fees.

AUTHORIZATION TO RELEASE INFORMATION

*I hereby authorize Women's healthcare Associates of Redding to release any medical or incidental information that may be necessary to secure the payment of benefits. If your insurance requires prior authorization you are responsible for making sure our office gets a copy of that from your primary care doctor.

CONTACT INFORMATION AND INSURANCE CERTIFICATION

*I certify that the information given by me in applying for payment is correct.

*I authorize release of all records upon request.

*I request that payment of authorized benefits be made on my behalf.

*I further agree that a photocopy of these assignments shall be as valid as the original.

*I agree to be responsible for any costs associated with collection of funds owed to the practice, including but not limited to, collection agency fees, attorneys' fees, and court costs.

*In the event the account becomes delinquent and is assigned to a collection agency, I hereby authorize Women's Healthcare Associates of Redding and/or their agent to obtain a copy of my credit report from the national credit bureaus, including but not limited to TransUnion, Equifax, and Experian.

Patient/ Parent /Guardian – (PLEASE PRINT PATIENT'S NAME)

SIGNATURE **DATE**

WOMEN'S HEALTHCARE ASSOCIATES OF REDDING
AND
ASURITI CENTER FOR CONTINENCE AND PELVIC WELLNESS

EMERGENCY CONTACT INFORMATION

Patient Name: _____ DOB: _____

The purpose of this form is to gather pertinent information regarding emergency contact names(s) and number(s) that may be used in the event of an emergency situation on and/or off campus that renders you unable to communicate with appropriate staff members.

Please complete this information as well as include these persons in the HIPPA form that follows

Primary Contact Name: _____

Home Phone: _____Mobile Phone: _____

Address: _____

Relationship: _____ E-Mail (Optional): _____

Secondary Contact Name: _____

Home Phone: _____Mobile Phone: _____

Address: _____

Relationship: _____ E-Mail (Optional): _____

Patient / Parent / Guardian (PLEASE PRINT PATIENT NAME)

SIGNATURE **DATE**

WOMEN'S HEALTHCARE ASSOCIATES OF REDDING
AND
ASURITI CENTER FOR CONTINENCE AND PELVIC WELLNESS

Acknowledgement of Receipt of Notice of Privacy Practices and Release of Protected Health Information

A copy of Women's Healthcare Associates of Redding and Asuriti Center for Continence and Pelvic Wellness Notice of Privacy Practices is available in our office and on our website at www.dr4women.com.

Under the Patient Privacy Act, otherwise known as HIPAA, our office cannot release or discuss patient information with anyone other than the patient, custodial parent, or legal guardian, unless we have written authorization from the patient.

If you would like us to be able to speak to **family member, caregivers, or other entities** regarding your healthcare, please complete the following indicating the person(s), **BY FULL NAME,** to whom we may speak.

I, _____ authorize Women's Healthcare Associates of Redding and/or Asuriti Center for Continence and Pelvic Wellness to release or discuss my Private Health Information with the following person(s):

Name: _____ Relationship_____

Name: _____ Relationship_____

Name: _____ Relationship_____

[ ] Entire Record **or** **[ ]** Emergency Only

[ ] Specific Information Only: _____

[ ] I DO NOT WANT ANY INFORMATION RELEASED TO ANYONE BY WOMEN'S HEALTHCARE ASSOCIATES OF REDDING AND/OR ASURITI CENTER FOR CONTINENCE AND PELVIC WELLNESS, WITH EXCEPTION OF THE PHYSICIAN WHO REFERRED ME TO THIS PRACTICE.

This authorization shall remain in effect until which time I have revoked this authorization in writing. My written revocation must be submitted in writing to:
Women's Healthcare Associates of Redding, Privacy Officer, 2420 Sonoma Street, Suite B, Redding, CA 96001.

Print Patient Name: _____Signature: _____

Date: _____Relationship if other than patient_____

WOMEN'S HEALTHCARE ASSOCIATES OF REDDING
DISCLOSURE OF RELATIONSHIP

Dear Patient:

We are asking you to acknowledge that we did not direct or refer you to a particular laboratory or pathology group for your services. Shasta Pathology Associates is our preferred laboratory and is the only anatomic pathology lab in the Redding area. However, you are free to request your pathology be sent to any lab of your choice.

We are committed to compliance with any rules governing health care. Part of those rules requires that we disclose to you any financial interests we may have in businesses outside our office that we might use, or refer you to, as part of your medical treatment.

We are therefore asking you to acknowledge that we have advised you that one of our shareholders, Dr. Richard Mooney, is married to Julia E. Mooney, M.D., a practicing pathologist. Julia E. Mooney, M.D. is part of a medical corporation that is a partner in Shasta Pathology Associates (a Redding-based medical partnership).

If you have any questions about this, do not hesitate to ask. We do ask you to acknowledge that you have read and understand this disclosure.

I ACKNOWLEDGE THIS DISCLOSURE:

_____ _____

PATIENT SIGNATURE **DATE**

WOMEN'S HEALTHCARE ASSOCIATES OF REDDING

PATIENT SELF HEALTH ASSESSMENT

PATIENT NAME_____ DOB_____

REASON FOR VISIT_____

IN ORDER TO ACCOMMODATE PATIENTS WHO MY HAVE SPECIAL NEEDS, PLEASE ANSWER THE FOLLOWING QUESTIONS:

Do you require the use of any of the following? Wheelchair, Scooter, Cane or Walker. If yes please describe:

_____

Do you need transfer assistance? YES ___NO____ if yes, please describe_____

Do you require special transportation services such as transfer to a gurney? YES ___NO____

if yes, please describe_____

Do you need an interpreter? YES ___ NO ___ if yes, which language_____

Do you have a sight, hearing, or speech impairment? If yes, please describe _____

ALLERGIES / ADVERSE REACTIONS

Drug Names? _____What happens? _____

Drug Names? _____What happens? _____

Drug Names? _____What happens? _____

MEDICATIONS (Including hormones, vitamins, herbs, and over-the-counter medications)

Drug Name? _____Dosage? _____ Drug Name? _____Dosage? _____

Drug Name? _____Dosage? _____ Drug Name? _____Dosage? _____

Drug Name? _____Dosage? _____ Drug Name? _____Dosage? _____

Drug Name? _____Dosage? _____ Drug Name? _____Dosage? _____

Drug Name? _____Dosage? _____ Drug Name? _____Dosage? _____

Drug Name? _____Dosage? _____ Drug Name? _____Dosage? _____

Drug Name? _____Dosage? _____ Drug Name? _____Dosage? _____

Vaccines

Type? _____ Date? _____

Type? _____ Date? _____

Type? _____ Date? _____

GYN HISTORY

What was the first day of your last period? _____ Was it heavy/moderate/ light? _____
Do you have a period every month? _____How many days between, before starting next period? _____ How long do your periods last? _____ (ie days, weeks)
How old were you when you had your first period? _____Current Birth Control Method? _____ If Post-Menopausal, age at Menopause? _____ Are you taking/using Hormones? _____ When was your last Pap Smear? _____ Was it normal? _____abnormal? _____ When was your last Mammogram? _____ Was it normal? _____abnormal? _____
Have you ever had any of the following pelvic infections? (please check mark)
Yeast__Bacterial Vaginosis___Trichomonas___Gonorrhea___Syphilis_____Chlamydia__Herpes____

PATIENT'S OTHER PROVIDERS

Name: _____ Phone#_____

Name: _____ Phone#_____

Name: _____ Phone#_____

PATIENT'S HISTORY – OTHER

_____

_____

OBSTETRICAL HISTORY

How many times have you been pregnant? _____

Have you ever had the following? If yes, how many?

Abortion_____ Miscarriage_____ Multiple_____ Stillbirth _____ Ectopic_____

Living Children_____

PAST PREGNANCIES

Date of Birth	# of Fetuses	Labor Length	Birth Weight	Sex	Delivery type (vaginal or cesarean section)
_____	_____	_____	_____	___	_____
_____	_____	_____	_____	___	_____
_____	_____	_____	_____	___	_____
_____	_____	_____	_____	___	_____
_____	_____	_____	_____	___	_____
_____	_____	_____	_____	___	_____

SOCIAL HISTORY

Do you exercise? _____ How Often? _____ How Long? _____
Do you smoke cigarettes? _____ If yes, how many cigarettes per day? _____
Have you ever smoked cigarettes? _____ If yes, how long did you smoke? _____
Do you drink alcohol? _____ If yes, how many per day? _____ per week? _____ per month? _____
Illicit Drugs (street/illegal drugs)? _____ If yes, what type? _____ How often? _____
Deaf or serious difficulty haring? _____ Blind or serious difficulty seeing? _____
Difficulty concentrating, remembering or making decisions? _____ Difficulty walking or climbing stairs? _____ Difficulty dressing or bathing? _____
Difficulty doing errands alone? _____

SURGICAL HISTORY

What surgeries have you had in the past?

_____Year?	**_____**	**Hospital? _____**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PERSONAL MEDICAL HISTORY

If you have a problem now, or if you have had a problem with any of the following body systems in the past, please check. If you never have, please write N/A

_____Anemia
_____Anxiety Disorder
_____Arthritis
_____Birth Defects or Inherited Disease
_____Breast Cancer
_____Breast Problem
_____Cancer
_____Depression
_____Diabetes
_____Endometriosis
_____Fibromyalgia
_____GI problems
_____Headaches or Migraines
_____Heart conditions
_____Heart Disease
_____Hepatitis
_____Hyperlipidemia
_____Hypertension
_____Infertility
_____Kidney or Bladder Problems
_____Lung Disease
_____Obesity
_____Osteoporosis
_____Ovarian Cancer
_____Psychiatric Illness
_____Thyroid Problems

FAMILY HISTORY (Relatives who have had any of the above illnesses listed at the top of this page)

Relationship _____ Type_____mother's side/dad's side

Relationship _____ Type_____mother's side/dad's side

Relationship _____ Type_____mother's side/dad's side

SPACE FOR ADDITIONAL INFORMATION:

_____

_____

_____

_____

_____

_____

WOMEN'S HEALTHCARE ASSOCIATES OF REDDING
OFFICE POLICIES
EFFECTIVE JANUARY 1, 2016
KEEP THESE OFFICE POLICY PAGES FOR YOUR RECORDS

1. **Please arrive 15 minutes early.** Your promptness will ensure a full appointment within the time allotted. To ensure our providers stay on schedule, if you are 10 minutes late or more, your appointment will be rescheduled.
2. **A minimum 24-hour cancellation notice is mandatory**. We are a specialty practice and our doctors are scheduled weeks in advance. When a patient fails to show for their appointment or a procedure we have lost the opportunity to fill the time slot with another patient. **A $50 no-show fee for an office visit and a $100 no-show fee for a procedure will be assessed.** These fees cover lost revenue as well as prepared supplies that must be discarded if you do not show up for your appointment. Insurance does not reimburse for these fees. Payment of these fees will need to be paid before another appointment can be scheduled. NO EXCEPTIONS. We expect life's unforeseen events and communication from you will ensure that your needs and our requirements are met.
3. **Excessive Cancellations**. We take your healthcare seriously and so should you. If you are in need of an appointment we ask that you refrain from cancelling with the exception of an emergency. We will terminate our relationship with you if you excessively cancel, reschedule, arrive late, or no show for your appointments as we feel we cannot adequately follow you for your healthcare needs.
4. **Copayment/Co-Insurance.** All copayment and coinsurance amounts due will be expected at the time of service. We accept cash, checks, credit and or debit cards to cover these amounts due. If you do not come prepared to pay your balance due, your appointment will be rescheduled. It is our goal to keep our costs as low as possible. We can only accomplish this by collecting all monies due at the front-end of your appointment and avoid further collection efforts by our staff and outside agencies.
5. **Form Fees.** Completion of forms is not considered direct patient care. For this reason, there will be a fee of $20 for the first page of each form we complete and $5 for each additional page requested by any **outside organization or facility**. When forms are completed, you are responsible for picking up the form(s) and paying the fee(s). We will not mail forms. This fee does not apply to patient registration forms or our office generated forms.

6. **PLEASE NOTE: We use Professional Medical Copy for all copying of patient medical records. If you request your records, they will copy them and will send you a bill. We do not negotiate these fees for you or with you. If you have questions regarding the fees associated with copying your medical records, please contact Professional Medical Copy directly at (530) 241-2971.**
7. **Childcare Policy.** Our office space and examination rooms are equipped for providing services to adult and adolescent women and these areas are not "childproof." We do not provide child care nor do we have a designated children's area. So your attention and ours can be directed to your patient care, we encourage you to consider an alternative arrangement for your children during the time you are scheduled for an appointment in our office. If you are unable to arrange childcare, we will need to reschedule your appointment for another time.
8. **Cell Phones.** As a courtesy to our doctor, staff and other patients, cell phones use is **prohibited** while in our facility. We will ask you to abide by this policy if we see your cell phone being use.
9. **Automated Calls.** Women's Healthcare Associates of Redding utilizes an entirely electronic health record system. This system provides automated calls regarding important notifications that may need to be sent to you. Regulations require us to get your permission for automated calling.

WOMEN'S HEALTHCARE ASSOCIATES OF REDDING

POLICY REGARDING PRESCRIBING OF NARCOTIC MEDICATIONS

PRE-OPERATIVELY AND POST-OPERATIVELY

Patient Name: _____ DOB: _____

In our endeavor to protect patients and act within the strict State and Federal Government prescribing guidelines. Women's Healthcare Associates of Redding (WHAR) takes the prescribing of narcotic pain medications very seriously. For our patients' safety we have developed this office policy regarding prescribing narcotic pain medications pre and post-operatively for all of our patients. We have developed this policy in collaboration with our colleagues in pain management to reflect current standards regarding the issuance of narcotic pain medication for patient who are recovering post-operatively while taking narcotic pain medication under the care of another provider (primary care of pain management specialist).

_____ I understand that I must report the use of ANY chronic pain medication use (meaning any narcotic medication being prescribed more than one time), at the onset of my care at WHAR.

_____ I understand that any time while I am a patient at WHAR and am prescribed chronic narcotic medications I will report that to my medical provider immediately.

_____ I understand that WHAR will ask me to update my medication reconciliation at all appointments and I will truthfully report all such medications.

_____ I understand that if I am currently being prescribed narcotic pain medication by ANY OTHER medical providers for chronic pain issues, WHAR will only provide the customary narcotic pain medication for 5-7 days of use for your post-operative pain control.

_____ I understand that WHAR will provide no more than 30 tablets of narcotic pain medication, (such as Norco or Tylenol #3)

_____ I understand that WHAR will not assume any management of unrelated chronic pain issues post-operatively.

_____ I understand that WHAR will issue my post-operative narcotic pain medication prescription at my pre-operative appointment. This is the only narcotic pain medication prescription that will be given. I understand that it is my responsibility to safeguard my written prescription for pain medication as well as my filled pain medications and only take it for post-operative pain. WHAR will not re-write narcotic pain prescriptions for any reason.

Patient Name: _____ DOB: _____

_____ I understand that post-operatively, I will contact my primary care physician and or pain management specialist for any refills of narcotic pain medications.

_____ I understand that it is my responsibility to notify my primary care provider and or pain management provider, prior to my scheduled surgery, of the date, type of surgery, and expected date of discharge.

_____ I understand that if I am currently on chronic narcotic medications or on a pain contract with any other medical provider, I will discuss the use of pre and post-operative pain management with the prescribing provider to ensure that I receive proper medical advice as to any adjustment of the dose or type of narcotics that may be necessary pre and post-operatively.

_____ I understand that WHAR WILL NOT prescribe any narcotics, make adjustments of the dose or type of narcotics, and we WILL NOT assume the role of management or treatment of pain related to any ongoing chronic pain condition, which may be exacerbated with undergoing surgical procedures.

_____ To the extent permitted by law, I understand an authorize WHAR and any pharmacy where I fill my prescriptions to fully cooperate with city, state and federal law enforcement agency investigation of possible misuse, sale or other division of my pain medication.

_____ I understand and authorize WHAR to provide a summary of my upcoming surgery and report any prescriptions, including name of narcotic pain medication, quantity of pain medications and date written to your pain management provider and your referring physician.

_____ I understand that any non-compliance with this policy will be grounds for immediate dismissal for further medical services from WHAR.

I have had the opportunity to read and ask questions regarding this policy. I agree to fully cooperate with and abide by this policy.

_____ _____

Patient, Parent or Person Authorized to Sign for Patient Date

About Telemedicine
WHAT IS TELEMEDICINE?

Telemedicine (also sometimes called telehealth) services are a way to deliver healthcare services locally to a patient when the healthcare provider is located at a distant site. Telemedicine is generally defined as the use of electronic information and communications technology to exchange medical information from one site to another site to provide medical and/or surgical treatment to a patient an or to participate in the medical diagnosis of, or medical opinion or medical advice to, a patient.

Women's Healthcare associates of Redding currently utilizes audio only telemedicine services, when a healthcare provider believes a patient may benefit you from this service. Telemedicine services often provider a broader access to medical care, eliminates transportation concerns, and increases comfort and familiarity for the patients and their families when located in their own homes or other local environments.

Telemedicine services may not be as complete as in-person healthcare services because the healthcare provider will not always be able to observe subtle non-verbal communications such as a patient's posture, facial expression, gestures, and tone of voice.

Any audio telemedicine conference provided to you via telephone will be treated as a face-to-face encounter and documented in your medical record the same as any in-person encounter would be documented. These telemedicine encounters will be billed to your insurance the same as in office visits.

I read and understand the information provided in this document. I discussed any question I had with my doctor and all of my questions were answered to my satisfaction.

_____ _____

Date Patient's Signature