Women's Healthcare
of Norman

Women Caring for Women

Leslie Ollar-Shoemake, D.O. • Lisa Waterman, D.O. •
Daphne Lashbrook, M.D. • M. Dianne Chambers, M.D. • Allison Carter, M.D. • Jessica Hinojosa, D.O.

Welcome to Our Practice

We would like to welcome you as a patient to our practice. We would like you to know some basic information about the way our office works.

⌘ Paperwork

You will be asked to complete a health history prior to your first visit. This allows us to have complete and accurate information at the time of your visit. We also ask that you bring copies of your past medical records if you have them in order to assist with obtaining a complete medical history. Please know that we respect your health information and your privacy is very important to us. All of your personal health information will be kept strictly confidential.

⌘ Insurance

You will need to bring your insurance card, driver's license, and co-pay with you to every visit. Insurance company contracts state that we must collect co-pay from you at the time medical services are rendered. Several insurance companies require a referral from you primary care physician before you can be seen by an OB/GYN. Please call your insurance company to verify if this is required and obtain the referral prior to the date of your appointment. We will be unable to see you if the referral is not complete.

⌘ Prescriptions

Prescription refills will only be done during office hours. The on-call physician will not be able to provide any prescriptions or refills after regular office hours. She does not have access to your chart or any of your information. Please keep this in mind and try to call a week before you run out of medication. If you need a refill, you will need to call your pharmacy, let them know which medication you need. They will fax a "refill request" to our office. The nurse will then fill out the needed information and fax it back to the pharmacy. Please allow 24 hours for this process to take place.

⌘ Office visit

As doctors dedicated to women's health care, we strive to see each patient in a timely manner. However, due to the nature of our practice, we may be called to deliver a baby and/or handle a hospital emergency. Due to these issues, there may be a delay from our appointment time. We apologize for any inconvenience this may cause, and we will try our best to keep you updated on any unexpected wait. We are committed to providing the best care possible to all of our patients.

⌘ Questions

We are always available to answer your questions. Please be aware that at certain appointments, we can only discuss certain issues. For example, if you are scheduled for a "well-woman" exam, and we discuss other issues or complaints, your insurance company may not pay for that visit. When you call to schedule your appointments, please let us know if you have other issues that you need to discuss so that we can schedule a separate appointment for you.

3440 R.C. Luttrell Dr.
Suite 200
Norman, OK 73072

Phone: 405-360-1264
Fax: 405-321-8683
Web: www.whcnorman.com

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⌘ Test Results

The nurses will contact you with your test results, unless you are told otherwise. Please keep in mind that some of the lab work we order takes several days to weeks to be completed. We will notify you as soon as possible. We know that waiting can cause a lot of anxiety, and we will notify you as soon as possible.

⌘ Coverage After Hours

We understand that most of our patients prefer to have their own doctor present at delivery. We also prefer to care for our own patients. However, please understand that it is impossible for any physician to be available 24 hours a day, 7 days a week. The six physicians in this office share call coverage for our patients. We try to deliver our own patients during office hours, but turn over care of our patients to the on call at night and during the weekend. It is also important to note that calls after office hours and during the weekend should be limited to emergencies only. We appreciate your understand in this matter.

⌘ Payment Methods

Payment is required at the time of service.

We accept cash, cashier's checks, and personal checks, Visa, MasterCard, American Express and Discover Cards.

If you have any question that this form has not answered, please feel free to ask.
Thank you for allowing us to be part of your health care. We appreciate you.

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*****Please COMPLETELY fill out all applicable information & return this form to the front desk*****

Patient Demographics

Patient Name: _____ **Date of Birth:**_____/_____/_____

Address:_____ **Social Security #:** _____

City:_____ **Language:**_____**Marital Status:** _____

State:_____**Zip Code:** _____ **Spouse's Name:** _____

Home #:_____**Leave Msg?**_____ **Your Cell #:**_____**Leave Msg?**

Your Work #: _____ **E-Mail Address:** _____

Race:_____**Ethnicity**: _____ **Your Place of Employment**:_____

***I hereby authorize the Physician's of WHC Norman to obtain/download my medical history from Pharmacies and/or Pharmacy Benefit Managers. This authorization will allow my physician to check drug to drug interaction for any new prescriptions that may be prescribed and to facilitate electronic pharmacy prescriptions. I understand this authorization will remain in effect until revoked by me in writing.**

Initial:_____**Date:**_____/_____/_____

Preferred Pharmacy Name:_____**Pharmacy Number:** _____

Contact Preference: (Please Circle) Home Work Cell Phone Mail Patient Portal

Referred By: _____

Patient Insurance Information

Primary Insurance

Insurance Name: _____
Subscriber's Name: _____
Subscriber's Relation: _____
Subscriber's SS #: _____
Subscriber's Date of Birth:_____/_____/_____
Subscriber's Policy ID #: _____
Subscriber's Group #: _____
Subscriber's Employer: _____
Subscriber's Address: _____

Secondary Insurance

Secondary Insurance: _____
Subscriber's Name: _____
Subscriber's Relation: _____
Subscriber's SS#: _____
Subscriber's Date of Birth:_____/_____/_____
Subscriber 'Policy ID#: _____
Subscriber's Group #: _____
Subscriber's Employer: _____
Subscriber's Address: _____

Emergency Contact:_____**Relation:**_____**Phone #**: _____
Emergency Contact Address: _____

Authorization

- **I hereby authorize the release of all my medical information necessary for the processing of Insurance Claims. I also authorize my insurance company to make payments directly to the Physician's of Women's Healthcare of Norman.**
- **I understand I am responsible for payment denied by my insurance due to lack of referral and/or inaccurate insurance information.**
- **I understand that I am responsible for obtaining referrals prior to my appointment.**
- **I understand that I am responsible for the payment of any portion of my bill not paid by my insurance company.**

Patient Signature:_____**Date**:_____/_____/_____

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First Name:_____ **Middle Initial:**_____ **Last Name:** _____

Primary Phone Number:_____ **Date of Birth:**_____/_____/_____ **Age:**_____

Ethnicity:_____ **Primary Language:**_____ **Marital Status:** _____

Reason for Visit: _____

◆ *This form is to help us understand your health history. It will allow us to ensure your records are complete so we can provide the best care possible at the time of your visit. We understand that your answers are very personal, and we will maintain them in the strictest confidence.* ◆

Past Medical History

List any medical illness:_____

_____

List any drug allergies: _____

_____

Do You Smoke? ❒*Yes* ❒*No* ***(If Yes, how much?)*** _____

Do you drink alcohol? ❒*Yes* ❒*No****(If yes, how much?)***_____

Do you use illegal drugs? ❒*Yes* ❒*No*

Date of last Mammogram:_____

Date of last Colonoscopy: _____

Date of last Dexa Bone Scan: _____

List any medications (*Name, Dosage, How often taken*):_____

_____

_____

List any SURGERIES and YEAR it was performed: _____

_____

_____

OB History

Are you currently pregnant? ❒*Yes* ❒*No*

How many pregnancies have you had? _____

Number born before 37 weeks? _____

How many living children do you have? _____

Have you had a miscarriage? ❒*Yes* ❒*No*

Have you had an abortion? ❒*Yes* ❒*No*

Have you had a C-Section? ❒*Yes* ❒*No* (***If yes, how many?)***_____

Gyn History

First Day of Last Menstrual Period: _____

Age of First Period: _____

How often do you have a period? _____

How many days does it last? _____

Date of last Pap Smear: _____

Have you ever had an abnormal Pap Smear? ❒*Yes* ❒*No*

If yes, when? _____

Treated with: ❒ ***Follow-Up Pap Smear*** ❒ ***Colposcopy*** ❒ ***LEEP***

Are you currently sexually active? ❒*Yes* ❒*No*

Sexual Partners: ❒*None* ❒One ❒2-5 ❒*More than 5*

Have you ever had a sexually transmitted disease? ❒*Yes* ❒ *No*

Method of birth control: _____

Have you ever used Gardasil? ❒*Yes* ❒*No*

Family History

****Have you had or any members of your family had:***

	You	***Family*** ***(List who and what side)***
Heart Disease	❒	❒ _____
High Cholesterol	❒	❒ _____
High Blood Pressure	❒	❒ _____
Diabetes	❒	❒ _____
Thyroid Problems	❒	❒ _____
Hepatitis (Type___)	❒	❒ _____
Tuberculosis	❒	❒ _____
Anemia or Blood Disorder	❒	❒ _____
AIDS or HIV	❒	❒ _____
Birth Defects- Inherited Diseases	❒	❒ _____

****Have YOU ever had any of the following:***

- ❒ **Liver Disease**
- ❒ **Stomach, Bowel, or Gallbladder Problems**
- ❒ **Blood Transfusion**
- ❒ **Infertility**
- ❒ **Rheumatic Fever**
- ❒ **Allergies**
- ❒ **Kidney or Bladder Problems**
- ❒ **Cancer (What Type?)** _____
- ❒ **Asthma**
- ❒ **Syphylis** ***Type:***_____
- ❒ **Herpes (HSV)** ***Type:*** ___
- ❒ **Chlamydia**
- ❒ **Gonorrhea**
- ❒ **Breast Problems**
- ❒ **Sexual Problems**
- ❒ **Sexual Abuse or Domestic Violence**

Important Information Regarding "Annual" Well Woman Exams

Our office makes every effort to follow the current coding practices for reporting medical services as dictated by Federal Law and the American Medical Association (AMA). These regulations can be quite complicated and generate many questions from our patients. The purpose of this handout is to clear up any confusion caused by these complicated rules regarding the billing of Preventative and Screening Services.

***The "Well Women" Exam covers the following*:**

A complete history and examination including a breast and pelvic exam. Counseling on risk factors such as: sexually transmitted disease prevention, diet and exercise, stress management, smoking cessation, Self-Breast Exams, birth control, menopausal symptoms and hormone replacement therapy. Discussions about existing conditions that we are currently treating you for i.e. hormones and birth control are considered an integral part of the Well Woman exam and will not be billed as a "sick visit" under Federal Compliance rules.

The collection/preparation of a Pap smear specimen is included if indicated; it will be submitted to a lab and you will be billed by that entity not WHC. Appropriate diagnostic tests, such as a mammogram and DEXA, may also be ordered and will be billed by those entities not WHC.

Note: Please be advised it is the patient's responsibility to inform staff if your insurance carrier requires the use of a specific laboratory.

_____Initial

***If a separate problem is identified, addressed or treated during the course of your "Wellness Exam" we will submit a claim based on the documentation in the medical record of the service provided to you. This may result in a second office visit charge and/or second co-pay. ***

_____Initial

If you are scheduled for your Well Woman Exam today and are aware of problems you would like to discuss, please inform the nurse. In this event, your appointment may be converted to a "problem appointment" due to the time restraints and to avoid additional costs to you.

_____Initial

You as the insured will be responsible for payment as dictated by your insurance plan of all co-payments and deductibles at the time of service. Again, if an additional problem is treated or addressed during this exam, there may be an additional charge that you will be responsible for.

_____Initial

I understand the above information and agree to pay any charges incurred due to discussion/treatment of a problem during a Well Woman Exam.

_____ _____/_____/_____

Print Name **Date of Birth**

_____ _____/_____/_____

Patient Signature **Today's Date**

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Financial Policy

Dear Patient:

Your physician is honored that you have chosen her. The following is her Financial Policy. Her main concern is that you receive the proper and optimal treatment needed. Therefore, if you have any questions or concerns about the payment policies, please do not hesitate to ask the billing department. All patients are asked to read and sign the Financial Policy as well as complete the Patient Registration form prior to see their doctor.

Payment for services is due at the time services are rendered. Your doctor accepts cash, checks, MasterCard, Visa, Discover, and American Express. The office staff will be happy to file your insurance claim for you. However, please be aware that, although your physician has contracts with several insurance companies, she is not on all PPO or network plans. Please be sure to inquire as to your physician's status with your particular insurance company, as this may affect the amount you are responsible for paying.

Please note that if you are a member of an HMO or Managed Care program and/or have a primary care physician (PCP), you are responsible for contacting your PCP for a referral number prior to your visit, if applicable. If you fail to do so, your visit(s) may not be covered by your insurance, making you financially responsible.

All charges are your responsibility whether your insurance pays or not. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. Fees for these services along with unpaid deductibles and co-payments are due at the time of treatment. If the insurance company does not pay your claim within a reasonable time frame, you will be required to follow up with them and/or pay the balance.

During the course of your medical care, it may be necessary for one or more physicians to assist with your medical treatment. You agree to acknowledge that any overpayment or credit balance that you may have with one of the practices within the office is hereby assigned to any of the other practices within the office to which you may have a debt or outstanding balance due. To the extent that you have no balance due to any of the practices within the office upon completion of your medical treatment, any overpayment will be refunded 90 DAYS AFTER ALL CLAIMS HAVE BEEN RESOLVED.

Temporary financial problems may affect timely payment of your balance. It is imperative that you communicate such problems to the billing department so that they can assist you in the management of your account.

I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorized the doctor and staff to release all information necessary to secure the payment of benefits.

Print Name_____ Date of Birth_____/_____/ _____

Patient's Signature_____ Date_____/_____/ _____

◆Again, thank you for choosing us as your health care provider. Your physician appreciates your trust and appreciates the opportunity to serve you.

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STANDARD AUTHORIZATION TO USE OR SHARE PROTECTED HEALTH INFORMATION (PHI)

I. INDIVIDUAL INFORMATION (FOR PERSON WHOSE INFORMATION WILL BE SHARED)

Name Date of Birth

Address City

Area Code & Telephone Number State Zip

II. SCOPE & PURPOSE FOR SHARING INFORMATION

I understand protected health information is information that identifies me. The purpose of this authorization is to allow Women's Healthcare of Norman, LLC to share my protected health information.

III. AUTHORIZATION & INFORMATION TO BE SHARED

I authorize Women's Healthcare of Norman, LLC as set forth below, to share my protected health information for reasons in addition to those already permitted by law.

A. Persons/Organizations Authorized to Receive My Information: (Please do not include other physicians or your employer in this list)

(Name, Address, Phone & Fax) Relationship Purpose

B. Information to be shared

1. Check one or more boxes below. (Please check the appropriate box's for authorization)

- ❒ Entire Medical Record (includes all records except Psychotherapy Notes)
- ❒ Psychotherapy Notes
- ❒ Mental Health Records
- ❒ Pathology Report
- ❒ History and Physical
- ❒ Operation Report(s)
- ❒ Progress Notes
- ❒ Consultation Report(s)
- ❒ Discharge Summary
- ❒ EKG Report(s)
- ❒ Laboratory Report(s)
- ❒ Radiology Report(s)
- ❒ Physician's Orders
- ❒ Radiology Films
- ❒ Alcohol or Drug Abuse Records
- ❒ Other

2. Covering Services Between __ ____ ____ _ and_ __ _____ (Insert either date(s) or "all.")

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IV. EXPIRATION & REVOCATION

A. This Authorization will Expire (must choose one):

❒ 3 years after last office encounter ❒ other (insert date or event): _ _ __ _ _ _ _ __

B. Right to Revoke

I understand I may change this authorization at any time by writing to the address listed at the bottom of this form. I understand I cannot restrict information that may have already been shared based on this authorization.

V. ACKNOWLEDGEMENTS & SIGNATURES

A. Acknowledgements

1. I understand this authorization is voluntary and will not affect my eligibility for benefits, treatment, enrollment, or payment of claims.
2. I understand if the person/organization authorized to receive my protected health information is not a health plan or healthcare provider, privacy regulations may no longer protect the information.
3. I understand I may inspect or obtain a copy of the protected health information shared under this authorization by sending a written request to the address listed at the bottom of the form.
4. I understand, Leslie Ollar-Shoemake, D.O., Lisa Waterman, D.O., Daphne Lashbrook, M.D., Dianne Chambers, M.D., Allison Carter, M.D., and Jessica Hinojosa, D.O. collectively known as Women's Healthcare of Norman, LLC as members of Oklahoma Physician Health Exchange (OPHX), may utilize an electronic network to exchange my protected health Information with other providers unless I choose not to participate.
5. **I acknowledge information authorized for release may include records which may indicate the presence of a communicable or non-communicable disease.**
6. **Acknowledgement of Notice of Privacy Practice:** A complete description of how my medical information will be used and disclosed by Women's Healthcare of Norman is in the "Notice of Privacy Practice", which I should read before signing this agreement. A copy has been offered to me and is posted in the clinical site.

B. Signature

This document must be signed by the individual or the individual's legal representative.

Signature (Patient or Legal Representative) Date

Printed Patient or Legal Representative Name Capacity of Legal Representative (if applicable)

Physicians and Clinic Address:

Leslie Ollar-Shoemake, D.O., Lisa Waterman, D.O., Daphne Lashbrook, M.D., Dianne Chambers, M.D., Allison Carter, M.D., and Jessica Hinojosa, D.O.

Collectively known as **Women's Healthcare of Norman, LLC**
3440 R.C. Luttrell Dr. Suite #200
Norman, Oklahoma 73072
HIPAA Document – Retain a minimum of 6 years

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Fees and Guidelines for Patient's Request for FMLA Paperwork Completion

& Medical Records

It is the policy of Women's Healthcare of Norman to charge for the completion of Medical Forms/Medical Leave Forms/Disability Forms/ Copying of Medical Records. Please review the below policy guidelines and fees associated with the completion of these forms.

1. Medical Forms/Medical Leave Forms/Disability Forms/ Copying of Medical Records will be completed on average within 7 to 10 business days upon receiving the form in the office. Please be advised yourphysician will not manipulate disability effective dates. Your treating Physician must sign off on all medical record releases prior to the release of the records.

2. Please make sure that there is plenty of time allowed for completion of the forms. Emergencies will be handled on a case by case basis.

3. There will be a $25.00 fee for initial completion of forms. If additional paperwork is required a charge of $5.00 per page will be charged.

4. Medical Records copying fee; One Dollar ($1.00) for the first page and fifty cents ($.50) for each subsequent page.

5. Payment is due when the forms are completed and picked up, mailed orfaxed.

*Please understand that the increased administrative demands imposed on your physician takes valuable time away from actual patient care tasks. This time adds up when considering the number of patients seen by the practice making it necessary to bill.

If you have any question please feel free to ask a staff member.

Thank You,

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Women's Healthcare of Norman has exciting news regarding your health care!

As we continue in our efforts to provide you, our patients, with the highest quality of care, we are constantly looking for methods of working together with you to ensure that you are not only aware of but also involved in the maintenance and improvement of your health. To that end, we are proud to announce that our practice offers you the opportunity to use the power of the web to track all aspects of your health care through our office. The Patient Portal enables our patients to communicate with our practice easily, safely, and securely over the Internet.

Some of the portal features

Appointments Schedule, re-schedule, or cancel appointments online. Receive appointment confirmation/reminder notifications.

Refills Request Refills from your doctor for authorized medications before you run out. Improved compliance means improved health

Secure Messaging Ask questions of doctors, nurses and staff members

Lab Reports View the results of labs and imaging studies once your healthcare provider has reviewed them

Statements and Payments View statements and make online payments

Also access your health records from your phone through the healow mobile app

GET IT ON Google Play

Download on the App Store

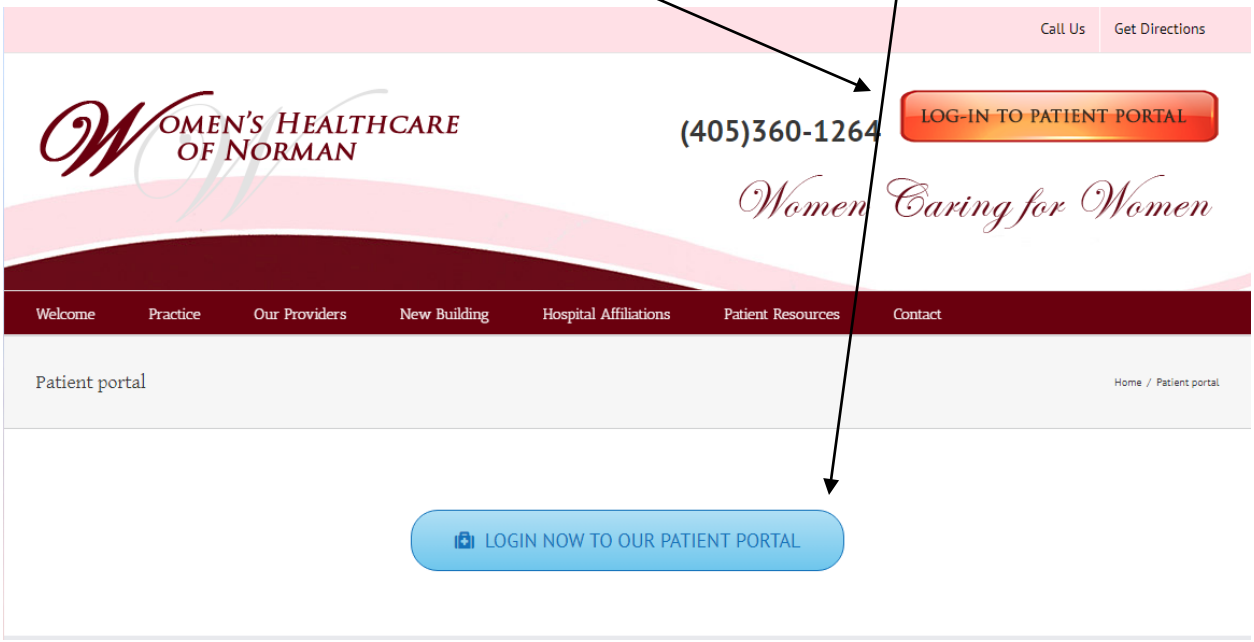
Our unique practice code is AECFAA

PATIENT PORTAL
TROUBLESHOOTING

If patient:

- Does not receive activation e-mail OR
- Forgets password

Go to www.whcnorman.com and click on LOG-IN TO PATIENT PORTAL and then LOGIN NOW TO OUR PATIENT PORTAL



Click on Login to your account Using Mobile Phone and follow prompts