Patient Information

Please Print

Last name _____First Name _____Middle Initial_____

Date of Birth_____ Age_____ Social Security Number _____

Address_____ City_____ State_____ ZipCode _____

Home Phone _____ Cell Phone_____

Occupation_____Employer_____

Emergency Contact (*include phone number)*_____

Whom may we thank for referring you?_____

Name of Primary Insurance Company_____

Primary Cardholder Name_____ Date of Birth_____

Policy/Member ID#_____ Group #_____

Name of Secondary Insurance Company_____

Policy/Member ID#_____ Group #_____

I certify that I, and or my dependent (s) have coverage with the above named Insurance Company(ies)and assign directly to North Scottsdale Women's Health all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am finally responsible for all charges whether or not paid by insurance. I authorize my signature on all insurance submissions.

The above named office may use my health care information and may disclose such information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature of patient or Legal Guardian _____Date_____

Printed Name or Legal Guardian_____ Relationship to patient_____

Notice of Privacy Practices

This Notice describes how your medical information may be used and disclosed and how you can get access to this information. Please review it carefully. You have the right to obtain a copy of our most up-to-date Notice upon request to our offices or online. Under federal law your patient health information is protected and confidential.

Patient health information (PHI) includes all information related to your past, present, or future health condition(s) that individually identifies you or could reasonably be used to identify you and is transferred to another entity or maintained by North Scottsdale Women's Health, PLLC in spoken, written, electronic, or any other form. Your health information also includes billing, payment, and insurance information. North Scottsdale Women's Health (NSWH) takes the security and privacy of your PHI seriously.

How We Use Your PHI

NSWH may use your health information for treatment, to obtain payment, and for health care operations; including evaluation of the quality of care you receive. Under some circumstances we may be required to use or disclose information without your permission.

Special Uses and Other Disclosures:

We may use your information in an attempt to contact you with appointment reminders, provide you with information about alternative treatments or other health-related benefits and services that may be of interest to you. Subject to certain requirements, we are permitted to give out your PHI without consent for the following purposes:

- ***Required by Law:*** When required by law to report information to report information about abuse, neglect, or domestic violence to public authorities if a reasonable belief exists that you may be a victim of such abuse
- ***Public Health Activities***:
- ***Judicial & Administrative Proceedings*****:** We may disclose PHI in response to an appropriate subpoena or court order.
- ***Law Enforcement Purposes*****:** We may disclose PHI when required by law enforcement.
- ***Deaths*****:** We may disclose information regarding deaths to coroners, medical examiners, and similar personnel.
- ***Serious Threat to Health & Safety*****:** We may disclose PHI when necessary to prevent a serious threat to your health and safety, the health and safety of others.
- ***Research***: Subject to certain conditions, we may use or disclose PHI for approved medical research.
- ***Worker's Compensation***: We may disclose PHI for worker's compensation or similar programs. In all other situations we will ask for your written authorization before using or disclosing any identifiable health information. If you choose, you may authorize to disclose information which you may later revoke for any future uses and disclosures.

Initials_____

-Individual Rights

Your rights with regard to your PHI:

-Request Restrictions: You may request restrictions on certain uses or disclosures of your PHI.

-Confidential Communications: You may ask us to communicate with you confidentially, for example, by sending notices to a special address.

-Inspect & Obtain Copies: In most cases, you have the right to view and/or receive a copy of your PHI. There may be a fee associated with copies.

-Amend Information: If you believe information in your record is inaccurate or incorrect, you have the right to request that modify or amend information related to your PHI. This is request does not guarantee a change will be made.

-Accounting of Disclosures: You have the right to request a list of certain disclosures of your PHI for reasons other than treatment, payment, or health care operations.

Our Legal Duty

We are required by law to protect the privacy of your health information. We are also required to provide you this notice about our legal obligations and privacy practices regarding your PHI, and to abide by the terms currently in effect.

Changes in Privacy Practices

We may change our privacy practices at any time. If a change occurs, we will update our Notice and make a revised copy available to you in our office and on our website. To request a copy please contact our office or visit our website.

Complaints

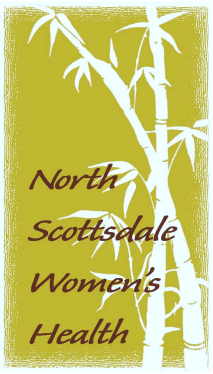
If you feel that we have violated your privacy rights, you may contact our office. You may also send a written complaint to the US Department of Health and Human Services. You will not be penalized in any way for filing a complaint.

North Scottsdale Women's Health
9745 N 90th Place
Scottsdale, AZ 85258
Ph: 480-661-1485 Fax: 480-661-1495

HH Office of Civil Rights
US Department of Health and Human Services
90 7th Street Suite 4-100
San Francisco, CA 94103
Ph: 415-437-8310 Fax: 415-437-8329

Printed Name_____

Signature_____Date_____



Consent for Messages

Patient Name_____ Date of Birth_____

Email Address_____

Consent for Message:

It is ok to leave messages on my cell phone # _____

- Appointments
- Test Results
- Billing/Insurance

It is ok to leave messages on my home phone #_____

- Appointments
- Test Results
- Billing/Insurance

Personal Representatives (family members, other health professionals etc) I authorize North Scottsdale Women's Health and its employees to discuss, send and/or receive medical information to/with the following individuals, including leaving a message with them:

Name/Relationship _____

Name/Relationship _____

General Practitioner/Referring Physician_____

If you would like your health records shared with above named Physician, please let the staff know upon check out.

Patient Signature_____ Date_____

North Scottsdale Women's Health

Patient Medical History Form

Name _____ Date of Birth_____ Age_____

Date of most recent:	**Normal** or	**Abnormal**	**Explanation (if needed)**
PapSmear _____	____	____	
Mammogram_____	____	____	_____
Colonoscopy_____	____	____	_____
BoneDensity_____	____	____	_____
Gardasil _____	____	____	_____

Menstrual History

Age of first period _____ Date of Last period_____

Regular _____ Irregular _____ Absent _____

They occur how often? _____ days They generally last_____ days

The flow is:
Light _____ Medium _____ Heavy _____ Variable _____

Cramps are:
Mild _____ Average _____ Severe _____

What medications do you take to relieve cramps?_____ Is this helpful_____

If Menopausal, are you on Hormone Replacement? _____ If yes, how long _____

Are you sexually active? Yes___ No___ Never ___

New Partner since last exam? Yes___ No___ Never___

Are you concerned of exposure to a sexually transmitted disease? Yes_____ No_____

Sexual Preference: heterosexual_____ homosexual_____ bisexual_____

Method of Pregnancy Prevention:

- ☐ Condoms
- ☐ NuvaRing
- ☐ Partner with vasectomy
- ☐ Birth Control pills
- ☐ Tubal Ligation
- ☐ Essure
- ☐ Natural family planning
- ☐ Contraceptive Patch
- ☐ IUD (Mirena, Paragard, Skyla)
- ☐ Other _____
- ☐ None

Have you ever had a sexually transmitted disease?

- ☐ Chlamydia
- ☐ Gonorrhea
- ☐ Herpes (Oral/Vaginal)
- ☐ HIV
- ☐ Syphilis
- ☐ Condyloma
- ☐ Hepatitis C

Have you ever had an abnormal pap?
If yes, Date _____ Diagnosis _____

Treatment or follow up _____

Have you ever had any of the following (please provide dates if available)

☐ Colposcopy _____ ☐ Cryo Surgery_____ ☐ LEEP _____

☐ Laser/Conization _____

Have you ever had any of the following gynecological issues:

☐ Fibroids
☐ Ovarian Cysts
☐ Endometriosis
☐ Lichen Sclerosus
☐ PCOS

Obstetrical History

Date of Delivery	Gestational Age (how many weeks when you delivered)	Vaginal/ C-Section/ Forceps/Vacuum	Male/ Female	Weight	Complications, If any:

Medical History

Please mark the boxes below if you've ever been diagnosed with any of the following:

- ☐ Breast Cancer (date diagnosed)
- ☐ Cancer (other than breast)
- ☐ Anemia
- ☐ Arthritis
- ☐ High Cholesterol
- ☐ Asthma
- ☐ Kidney Disease
- ☐
- ☐
- ☐ Chicken Pox
- ☐ Depression
- ☐ Anxiety
- ☐ Diabetes
- ☐ Ischemic Colitis
- ☐ Pulmonary Embolus
- ☐ Blood Clotting Disorder
- ☐ Deep Vein Thrombosis (DVT or bloodclots)
- ☐ Epilepsy
- ☐ Seizures
- ☐ Heart Attack/Heart Disease
- ☐ Liver Disease
- ☐ Migraines
- ☐ Mitral Valve Prolapse
- ☐ Pneumonia
- ☐ Sickle Cell
- ☐ Stroke
- ☐ Hypothyroidism
- ☐ Hyperthyroidism
- ☐ Thyroid Nodules
- ☐ Other _____

Blood Transfusion

Surgical History

Date	Surgery Performed	Reason for Procedure

Immediate Family History

(Please indicate if any, which family member has been diagnosed)

- ☐ Breast Cancer/Relative _____
- ☐ Colon Cancer /Relative _____
- ☐ Ovarian Cancer/ Relative_____
- ☐ Uterine Cancer/ Relative_____
- ☐ Diabetes/ Relative _____
- ☐ Heart Disease/ Relative _____
- ☐ High Blood Pressure/Relative _____

Please list all medications you are currently taking:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Please list all known allergies (medication and seasonal):

_____ _____

_____ _____

Social History

- ☐ Single
- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Widowed

Alcohol Use	Yes___	No___	If yes, _____ drinks per day/week/month
Tobacco Use	Yes___	No___	If yes, _____ packs per day for____years
Street Drugs	Yes___	No___	Type and frequency _____
Exercise	Yes___	No___	Type and frequency _____

Do you have any religious or cultural beliefs that would interfere with you receiving blood or blood products? Yes___ No___

Signature_____**Date**_____

AGREEMENT REGARDING PAYMENT TERMS AND CONDITIONS

Payments (copays, balances and self pay fees) for professional services are due at the time of service. We accept cash, personal checks Visa, MasterCard, Discover Card and American Express.

- **FEE FOR SERVICE AND PAYMENTS:** All estimated prices quoted to you are quoted under a fee for service arrangement. Under the fee for service arrangement, you will be charged for all of the services provided by NSWH.

This arrangement may not be modified by a verbal agreement. You will be financially responsible for all services provided, even if such services were not anticipated. Charges that are patient responsibility and remain unpaid after 30 days are subject to an administrative fee of $15.00 per billing cycle. Finance charges will start to accrue after 90 days.

Patients are required to pay ALL estimated deductibles, co-payments, and co-insurance amounts at the time of the pre-operative appointment or at 32 weeks for pregnant patients. Should there be any cost difference resulting in an under or over payment of the provided estimate vs. the actual cost of services, the patient will be invoiced for any balances due or the account will be credited with any over payment amount. Refunds are made at the conclusion of all services with NSWH.

- **LAB SERVICES:** Specimens will be sent out to your contracted lab for processing and billing. You will need to contact your insurance and the lab is there are any billing issues or questions

- **INSURANCE:** As the patient and contract holder with your insurance plan, you are ultimately responsible for payment of all charges not covered by your insurance. As the patient, it is your responsibility to know what your insurance covers and does not cover. If requested, our staff will assist you in providing a good faith estimate for your portion of the fee for services based on the information provided to us by your plan. However, we cannot guarantee what your insurance company will pay on a claim.. Please be aware that filing of claims is a *courtesy* our office provides to our patients, it does not guarantee payment to us. If we have received all of your insurance information at least 48 hours prior to the day of the appointment and we are able to confirm eligibility, we will be happy to file claims to contracted health plans on your behalf for covered services at North Scottsdale Women's Health. If you have insurance we are not contracted with or no insurance, our self pay rate is due at the time of service

BENEFITS ARE NOT DETERMINED BY OUR OFFICE Ultimately, it's your insurance company who decides what is applied to your deductible, what is considered your co-insurance or copay, and what you're financial obligation is for each service you receive. You can see the break down on the Explanation of Benefits (or EOB) that your insurance company sends you after they process the insurance claims. If you ever have any questions about your bill or need help understanding how your insurance company has determined your financial responsibility, feel free to all our billing department at 480-289-5945

Benefits quoted by your insurance plan are not a guarantee of coverage or payment. Coverage and payment is determined by your insurance when the claim is actually processed. Some insurance plans limit the number of procedures/care they will cover. Some insurance plans also limit the type of services/care covered. Occasionally, unique patient situations sometimes require additional procedures. These additional procedures may not be announced to you as "additional" by our clinicians, as they are providing you with care based solely upon your individual needs.

- **ASSIGNMENT OF BENEFITS:** If I am entitled to benefits of any type whatsoever under any policy of insurance, the benefits are hereby assigned to NSWH or to the provider group rendering service, for application on my bill. However, **I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT OF MY BILL**. In rendering treatment, NSWH is relying on my agreement to pay the account. I have read and understand the NSWH AGREEMENT REGARDING PAYMENT TERMS AND CONDITIONS and agree to be responsible for all charges incurred by me and to pay my account balance. If my account is sent to an attorney or collection agency, I agree to pay attorney's fees and/or collection agency expenses of up to a maximum amount of 40% of the debt, in additional to the original debt. The amount of the attorney's fee shall be established by the Court and not a jury in any court action. A delinquent account may be charged interest at the legal rate.
- **NO SHOW/CANCELLATION POLICY:** If you do not cancel your appointment within 24 hours prior to, the fee is $25. If you no-show your appointment, the fee is $25. If you reschedule or cancel your appointment more than 3 times, we will charge a fee of $25. These fees will need to be paid prior to scheduling any future appointments.

My signature on this document confirms that I have read, understand, and agree to the NSWH AGREEMENT REGARDING PAYMENT TERMS AND CONDITIONS.

Signature: _____ Date: _____

Printed Name: _____