Center For Women's Health

Offices at Cranbrook ¤ 10111 East 21st Street North ¤ Suite 301 ¤ Wichita, KS 67206

316-634-0060 ¤ 316-634-0050 (fax) ¤ cwhwichita.com

PATIENT INFORMATION

Last Name:	**First Name:**		
Address:	City:	State:	Zip Code:
Phone Number:	Marital Status:	Social Security Number:	
Primary Care Provider:	DOB:	Referring Physician:	
Email Address:		Significant Other's Name:	
Place of employment:			
Ethnicity:		Primary Language:	
Preferred Pharmacy:			

INSURANCE INFORMATION:

Primary Carrier:	Policy Holder's Name/D.O.B.: ☐ Self
Member ID:	Group Number:
Medical Claims PO Box:	

CONSENT TO TREATMENT:

I hereby grant consent for treatment or services to be provided by the providers of Center for Women's Health. I also certify that no guarantee or assurance has been made regarding the result that may be obtained.

QUEST DIAGNOSTICS:

Center for Women's Health uses Quest Diagnostics as our in-office laboratory vendor. Laboratory services including blood draw, pap smears, cultures or biopsies done in our office will be sent to Quest Diagnostics.

It is your responsibility to know if Quest Diagnostics is your in-network laboratory vendor.

If you do not want your laboratory services to be sent to Quest Diagnostics, please write your preferred laboratory vendor name below. We may be able to schedule a pick up for this specimen, otherwise you will need to take the lab order to your designated laboratory vendor.

Preferred Laboratory Vendor:

By signing this form, you acknowledge that you have consented to treatment as stated above as well as to using Quest Diagnostics as your laboratory vendor, unless you listed an alternative vendor.

Patient Signature:	**Date:**
☐ Updated. Signature:	Date:
☐ Updated. Signature:	Date:
☐ Updated. Signature:	Date:
☐ Updated. Signature:	Date:

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FINANCIAL POLICY

In the interest of good health care practice, it is desirable to establish a policy to avoid misunderstandings. Our primary responsibility is to help our patients experience good health, and we wish to spend our time and energy toward that end.

AGREEMENT:

- The patient is responsible for payment of all medical treatment and other related services covered by the treating provider at Center for Women's Health.
- As a service and out of consideration to our patients, this office will file insurance claims for all covered services. We will file up to two insurance companies. If you have additional coverage, you must file those yourself. We will not do 3rd party billing. This preparation is not a guarantee that we have a contractual relationship with your insurance plan, nor can we guarantee that your specific insurance policy covers the services that we have provided. It is a courtesy of CWH to provide an estimate of charges for procedures, surgeries, etc. but it is the patient responsibility to deal with insurance company.
- Self pay patients are responsible for all medical treatment and other related services covered by the treating provider at Center for Women's Health. While CWH will try to estimate services in advance, the patient agrees in advance to pay for all services, tests and fees the providers feel are necessary for the patient's care.
- We do not have a way to access the terms and conditions of your insurance policy and therefore are unable to speak on your behalf to your insurance company about contract disputes that you might have. If you believe that your insurance company has not paid your medical costs correctly, you should contact your company directly to negotiate a solution.
- This office will accept your insurance company's maximum allowable reimbursement. The patient will be responsible for any deductible, co-insurance and co-payment amount. The patient is 100% responsible for payment of any non-covered services at the time of service.
- Patient is responsible for all charges during their care; including laboratory charges, sonograms, and referrals to outside clinics for advanced testing and screening if necessary.
- Patients with insurance, which require a referral, must have a referral prior to receiving treatment. It is the patient responsibility to obtain all necessary referrals from the primary care physicians. Patients without proper referrals and electing to receive service from the office will be required to make full payments in advance of the time of service.
- Patients normally receive a statement from our clinic after the insurance company has processed the claims. This will include all charges that the insurance company has not paid. **Payment is due upon receipt.**
- **An 18% APR will accrue on balances not paid within the specified billing cycle, with a $10 minimum charge. Rates are subject to change without notice.**
- An account is considered past due if not paid by due date listed on billing statement, unless prior arrangements have been made with our billing office. If no attempts at payment have been made, the account may be referred to a collection agency.
- Patients may be discharged from care due to nonpayment of account.
- Patients who reserve an appointment with a provider and fail to keep that appointment will be subject to a $50 no-show fee; $100 no show fee for a scheduled procedure. To avoid this charge, patients must cancel appointments 24 hours prior to their reserved time. Fees are subject to change without notice.
- We accept cash, check, Visa, MasterCard, Discover, and debit cards. There is a $50 returned check fee.
- CWH may send you a refund check for services rendered; if this check is lost, stolen, or not received there is a $35 stop payment fee to reissue the check. We will not reissue checks for services later than one year.
- A copy of this form is available upon request.

INSURANCE RELEASE:

I authorize payment of medical benefits to the treating provider at Center for Women's Health to release any information requested by my insurance carrier.

I have read and understood the above agreement and by my signature here below, agree to the terms.

Patient Signature	Patient Printed Name	Date of Birth
Responsible Party Signature	Responsible Party Printed Name	
Relationship to Patient	Date	

Medical Information Release Form

(HIPAA Release Form)

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

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____

[ ] Child(ren)_____

[ ] Other_____

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number:_____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

The best time to reach me is (day)_____between (*time*)_____

Signed: _____ Date: ____/____/_____

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Credit Card on File Agreement

You are giving Center for Women's Health permission to automatically charge your credit card on file for your outstanding balances or any other patient(s) balances you have listed on this form at time of service.

I authorize Center for Women's Health to charge co-pays and outstanding balances on my account to the following credit card:

Visa_____ **MasterCard**_____ **Discover**_____ **American Express**_____

Credit Card Holder's Name: _____ (Please Print)

Last 4 of Credit Card # _____

Expiration Date: _____

Email for receipts:_____

Co-pays: Co-pays are due at time of the office visit.

Estimated responsibility for services: Estimated responsibility for procedures, laboratory services, office visits, etc are due at the time of the visit. Surgeries performed outside of the office are due two business days prior to the surgery.

Outstanding Balance: If your insurance provider has paid their portion of your bill or any other patient(s) you have listed on this form and there is still an outstanding balance owed, Center for Women's Health will notify you via mail. If the balance owed is not paid within 30 days, Center for Women's Health will charge the balance to your credit card. A copy of the charge will be emailed to you. This in no way compromises your ability to dispute a charge or question your insurance company's determination of payment.

This credit card on file is to be used for the following patient(s), please print name(s) below:
(expires after 1 year)

Patient Full Name: _____ DOB: ____ / ____ / _____

Patient Full Name: _____ DOB: ____ / ____ / _____

Patient Full Name: _____ DOB: ____ / ____ / _____

Multiple Users: This card will only be authorized for the use of the credit card holder, his/her minor(s), or any person(s) listed above. This agreement will expire for multiple users on an annual basis. If continued authorization is requested, another credit card agreement can be issued or a manager can verbally authorize and document the extension of an agreement.

Signature: _____ Date: _____

Frequently Asked Questions about the Credit Card On File Program

Why the change?
There are several reasons. First, statements are wasteful of paper, postage, and staff time. Second, we need to ensure that we have a guarantee of payment on file for each patient in our practice. We wait 20 to 30 days, and sometimes longer, for payment from your insurance company. Once that is received, we need to be sure that patient-responsible balances are paid in a timely manner.

But I always pay my bills, why me?
We have to be fair and apply the same policy to all patients. We have wonderful patients and we know that most of you pay your balances. Unfortunately, this is not always the case.

I have never had a Dr's office ask to keep my card on file. We realize this is a relatively new policy for a medical office. But it is no different from leaving a credit card on file with Amazon or I-tunes or your cell phone vendor. They only charge you when you order something or pay your monthly bill. We are doing the same thing after your insurance pays.

How will I know how much you are going to charge me? We will collect an estimated responsibility for your visit, procedure, laboratory service, etc. For every visit or surgery, your insurance company mails an Explanation of Benefits (EOB) to you. This document shows how much your insurance paid and what you need to pay based on the benefits and the deductible of your policy.

This office receives the same information that you do along with payment from your Insurance company. We apply the payment and make any discount or adjustment as per our contract with your insurance company. The balance on your account for that visit or surgery will then match the patient responsibility amount on your EOB. This is the amount that will be charged to your credit or debit card. A receipt will be sent to you via email.

What is a deductible? This is an amount of money that you must pay out of pocket every year before your insurance begins to pay. There are different deductibles for office services and hospital services. In the past few years, deductibles have been getting larger and larger. So patients have greater out-of-pocket costs over and above their co-payment for an office visit.

What if I have a really large bill? We are always happy to set up a payment plan. With our system, your card can automatically be charged each month. Contact our billing staff to discuss a plan.

What if I need to dispute my bill? All you have to do is call us, if you ever have a concern about your account. Mistakes can happen and we can apply a refund directly to your card if we have made a billing error. Unless you have directed monthly payments, we only charge the amount your insurance company has marked as patient responsibility as noted on your EOB.

What if I have 2 insurance plans? You are very fortunate!! Each plan may have different policy benefits and deductibles. Again, we will ask that you put a credit or debit card on file just in case these plans do not cover all your services. Remember, we will not access this information until both plans have paid AND if there is a remaining patient responsible balance.

I don't really know my insurance benefits. Can you tell me what they are? Unfortunately, there are SO many health plans that we are not able to know them all. We do verify that insurance plans are effective and what the status of your deductible may be, but we do not always know the exact benefits of your plan.

How do I find out about my benefits? It is important now more than ever that you know your health insurance plan.

Here are 3 ways to do it:

1. Review your plan benefits with your insurance agent;
2. If your plan comes from your job, you can review benefits with your Human Resources director;
3. Call Customer Service at your insurance company. The phone number is usually on the back of your insurance card.

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NAME:	**DATE:**
DOB:	

WELCOME:

Your accurate completion of this health history is greatly appreciated. This will allow us to more accurately address your health problems and make recommendations. This information enables us to spend more quality time evaluating your present concerns and less time on the collection process of your previous health history. Please let us know if you have any questions and thank you for your assistance.

Reason for today's visit? _____

Would you like to be tested for sexually transmitted infections? *Y / N*

Age: _____ Last Menstrual Period: _____/_____/_____

OBSTETRIC HISTORY:

Total Pregnancies: _____ Total Miscarriages: _____ Total Abortions: _____

Ectopic Pregnancy: _____ Children Living: _____

DATE	SEX	WEIGHT	TYPE OF DELIVERY	COMPLICATIONS

GYNECOLOGY HISTORY:

1. How old were you when your periods began? _____
2. Are your periods regular: *Y / N* How many days in a cycle? _____
3. How heavy is your bleeding? _____ How many days of bleeding? _____
4. Do you have cramping? ***mild / moderate / severe***
5. Age at first intercourse: _____ Total number of sexual partners: _____
6. Do you have a history of venereal disease such as gonorrhea, chlamydia, herpes, HPV, genital warts, or syphilis?

   _____
7. History of infection in the uterus and/or fallopian tubes? _____
8. History of sexual abuse: _____ Or physical abuse: _____
9. Date of last Pap smear: _____
10. Have you ever had an abnormal Pap smear? _____ When? _____
11. What is your birth Control Method: (please circle) none, condoms, spermicidal, foam, Depo-Provera, IUD(Mirena), IUD(Paraguard), Nexplanon, birth control pills, birth control patch, birth control ring, tubal ligation, vasectomy. Are you satisfied with this method? *Y / N*
12. Do you have a history of breast disease? _____
13. Do you perform monthly self breast exams? *Y / N*

PERSONAL MEDICAL HISTORY **Patient Name:**_____ **Date of Birth:**_____

Please list any allergies to medications: _____

_____

Please list any current medications /dosage you are taking (please include supplements and over the counter medications):

_____

_____

_____

Have you ever had any unusual childhood illnesses such as rheumatic fever or seizures? _____

_____

Who is your primary care physician? _____

PAST MEDICAL HISTORY:

Have you had any past history of medical problems in the following areas? If so, please describe:

1. Eye or visual problems: _____
2. Ear, nose or throat problems: _____
3. Thyroid disorder or diabetes: _____
4. Lung disease (such as pneumonia, bronchitis, asthma): _____
5. Heart problems or high blood pressure: _____
6. Liver or gallbladder disease (such as hepatitis, jaundice, or gallstones): _____
7. Stomach disorders (such as ulcers, gastritis, hiatal hernia): _____
8. Intestinal disorders (such as irritable bowel syndrome, colitis, polyps): _____
9. Urinary tract infections or kidney stones: _____
10. Anemia or blood clotting disorder: _____
11. History of DVT or other blood clot:_____
12. Ever prescribed blood thinning medications: _____
13. Bone or joint disease (such as arthritis or osteoporosis): _____
14. Neurological problems: _____
15. History of migraines; with or without Aura:_____
16. Mental disorders (such as depression, anxiety attacks, eating disorders, nervous breakdown): _____

SURGICAL HISTORY: Please list all surgery you have had and approximate dates:

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____
4. _____ Date: _____

TRAUMA HISTORY: Please list any broken bones, concussions, or injuries you may have had in the past:

1. _____
2. _____

HOSPITALIZATIONS:

1. _____
2. _____

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

FAMILY HISTORY: Please list any family members with the following illnesses (parents, grandparents, aunts, or uncles):

1. Heart disease: _____
2. High Blood Pressure: _____
3. Diabetes: _____
4. Clotting Disorder: _____
5. Cancer (please list type of cancer): _____
6. Endometriosis: _____

SOCIAL HISTORY:

Cigarette smoking: *Y / N* Amount: _____ per day For how long? _____
If no, have you ever smoked: *Y / N* Amount: _____ per day For how long? _____
Do you drink alcohol: *Y / N* Amount: _____
History of drug use: *Y / N* If yes, which drug? _____
Occupation or type of employment: _____

Do you exercise regularly? *Y / N*

Language you speak: _____ Your race: _____ Your ethnicity: _____

HEALTH/ RISK BEHAVIOR:

Do you wear sunscreen? ***Always / Usually /Sometimes / Never***
Are you exposed to occupational or recreational hazards? *Y / N*
Do you wear your seatbelt while riding or driving in a car? ***Always / Usually /Sometimes / Never***

TESTING:

Date of last pap smear: _____ Normal: *Y / N* if no, results _____
Date of last Mammogram: _____ Normal: *Y / N* if no, results _____
Date of bone density: _____ Normal: *Y / N* if no, results _____
Have you had any blood work, labs or x-rays in the past year? *Y / N* If so, please list: _____
_____
For those over 50, when did you have your last sigmoidoscopy / colonoscopy: _____

IMMUNIZATIONS:

When was your last Tetanus vaccine? _____
Have you had the HPV vaccine? *Y / N* Hepatitis B vaccine? *Y / N*

ADDITIONAL QUESTIONS OR COMMENTS:

_____
_____
_____
_____

PATIENT NAME: _____ **DATE:** _____

REASON FOR TODAYS VISIT: _____ **LMP:** _____

GENERAL:
- ☐ Weight loss
- ☐ Weight Gain
- ☐ Fever/ Chills
- ☐ Fatigue/ Weakness

SKIN:
- ☐ Nail Changes
- ☐ Hair Changes
- ☐ Mole Changes
- ☐ Skin Rashes
- ☐ Itchy Skin

EYES:
- ☐ Blurred/ Double Vision
- ☐ Glaucoma/ Cataracts
- ☐ Dry/ Itchy eyes
- ☐ Eye Glasses/Contact Lenses

EARS:
- ☐ Hard of Hearing
- ☐ Hearing Changes/ Deafness
- ☐ Ringing in Ears
- ☐ Ear Discharge
- ☐ Earache
- ☐ Dizziness

NOSE:
- ☐ Sinus Congestion
- ☐ Runny Nose
- ☐ Post Nasal Drip

MOUTH:
- ☐ Bleeding Gums
- ☐ Oral sores/ulcers
- ☐ Dental Problems
- ☐ Loss of Taste

THROAT:
- ☐ Difficulty Swallowing
- ☐ Throat Pain
- ☐ Hoarseness

NECK:
- ☐ Stiffness
- ☐ Soreness
- ☐ Pain
- ☐ Masses

BREAST:
- ☐ Nipple Discharge
- ☐ Lumps/Nodules
- ☐ Pain/Tenderness
- ☐ Breast Masses
- ☐ Nipple Bleeding

LUNGS:
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Wheezing

HEART:
- ☐ Murmur
- ☐ Irregular Heartbeat
- ☐ Palpitations
- ☐ Chest Pain

GASTROINTESTINAL:
- ☐ Change in Appetite
- ☐ Difficulty Swallowing
- ☐ Abdominal Pain
- ☐ Nausea/ Vomiting
- ☐ Bloating/ Gas
- ☐ Heartburn
- ☐ Constipation
- ☐ Diarrhea
- ☐ Rectal Bleeding

GENITOURINARY:
- ☐ Urgency
- ☐ Incontinence
- ☐ Frequency
- ☐ Pain with Urination
- ☐ Bloody Urine
- ☐ Urination at Night

BLOOD:
- ☐ Anemia
- ☐ Prolonged Bleeding
- ☐ Swollen Lymph Nodes
- ☐ Painful Lymph Nodes

GYNECOLOGIC:
- ☐ Break Through Bleeding
- ☐ Labial Sores
- ☐ Labial lumps/nodules
- ☐ Vaginal Discharge
- ☐ Vaginal Itching
- ☐ Painful Intercourse
- ☐ Menstrual Cramps
- ☐ Pain Between Periods
- ☐ Postmenopausal Bleeding
- ☐ Irregular menses
- ☐ Loss of Sexual Desire
- ☐ Night Sweats
- ☐ Vaginal Odor
- ☐ Pelvic Pain
- ☐ Infertility

MUSCULOSKELTAL:
- ☐ Muscle Pain/Cramps
- ☐ Weakness
- ☐ Joint Pain/Swelling

NEUROLOGICAL:
- ☐ Seizures
- ☐ Vertigo
- ☐ Paralysis
- ☐ Tingling/Numbness

PSYCHIATRIC:
- ☐ Depression
- ☐ Irritability
- ☐ Anxiousness
- ☐ Alcohol Abuse
- ☐ Suicidal Thoughts
- ☐ Sexual Difficulties
- ☐ Panic Attack
- ☐ Drug Addiction
- ☐ Physical Abuse

ENDOCRINE:
- ☐ Heat Intolerance
- ☐ Cold Intolerance
- ☐ Loss of Hair
- ☐ Extreme Thirst
- ☐ Excessive Hair Growth
- ☐ Hypoglycemia/Low Blood Sugar

OTHER CONCERNS:

_____
_____
_____
_____
_____
_____
_____
_____
_____

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

Do you have any concerns that this update did not cover? _____

Thank you for taking the time to provide this information!

Family History Screening Form

Patient Name: _____ Date of Birth: _____ Age: ____ Height: _____ Weight: _____
Your age at First Period: _____ Your age at First Childbirth (if applicable):_____ Are you Menopausal: Yes or No
If yes, your age at Menopause: ____ Have you ever used Hormone Replacement Therapy? Yes or No If yes, for how long? _____
Have you or anyone in your family had genetic testing for a hereditary cancer syndrome? Yes or No

Please indicate if you have a **personal or family history** of any of the following cancers. If yes, then **write family relationship** and **AGE at diagnosis**. **Consider parents, children, brothers, sisters, half- siblings, grandparents, aunts, uncles, nieces, nephews.**

BREAST AND OVARIAN CANCER (HBOC)

			You (age of diagnosis)	Siblings / Children (age of diagnosis)	Mother's Side (age of diagnosis)	Father's Side (age of diagnosis)
(Y)	N	EXAMPLE: *Breast Cancer*	_____	_____	*Aunt 53*	*Grandmother 45*
Y	N	**Breast Cancer**				
Y	N	**Breast Cancer in both breasts OR multiple primary breast cancers**				
Y	N	**Ovarian cancer** *(Peritoneal/Fallopian Tube)*				
Y	N	**Male breast cancer**				
Y	N	**Are you of Ashkenazi Jewish descent?**				

COLON AND UTERINE CANCER (LYNCH)

			You (age of diagnosis)	Siblings / Children (age of diagnosis)	Mother's Side (age of diagnosis)	Father's Side (age of diagnosis)
Y	N	**Endometrial (uterine) cancer**				
Y	N	**Colon/Rectal cancer**				
Y	N	**Ovarian, stomach, kidney, brain OR small bowel cancer** **Please specify relatives, type of cancer & their age at diagnosis.*				
Y	N	**10 or more colon polyps in a lifetime** *(Specify #)*				

Y	N	**Prostate Cancer (HBOC)**				
Y	N	**Melanoma (HBOC)**				
Y	N	**Pancreatic Cancer (HBOC/Lynch)**				
Y	N	**Other Cancers** **Please specify relatives, type of cancer & their age at diagnosis.*				

Patient's Signature: _____ Date: _____

For Office Use Only:
Patient offered hereditary cancer testing?
☐ YES ACCEPTED DECLINED
☐ NO

HEALTH CARE PROVIDER SIGNATURE: _____

1st degree: self, parents, siblings, children. 2nd degree: grandparents, grandchildren aunts/uncles, nieces/nephews, ½ siblings. 3rd degree: great grandparents, great aunts/uncles, 1st cousins.

HBOC - Personal or Family History

One person with: (out to 2nd degree)
-Breast (diagnosed <50)
-Ovarian, ANY age
-Male breast, ANY age
-Breast with Ashkenazi Jewish heritage, any age
-Bilateral breast at ANY age
-Triple Negative breast (diagnosed ≤60)
-Metastatic Prostate or Pancreatic at ANY Age
-Metastatic Breast at ANY age (personal history only)

Two persons with: (out to 3rd degree)
-Breast cancer (1 diagnosed ≤ 50)
-Breast & Ovarian Cancer, any age

Three Persons with: (out to 3rd degree)
-Breast and/or Pancreatic and/or Prostate, any age

Lynch*- Personal or Family History

One or Two persons with: (out to 2nd degree)
-Endometrial or Colorectal cancer (1 diagnosed ≤50)
-Endometrial or CRC cancer (1 ≤50) & another Lynch* cancer, any age

Three persons with: (out to 2nd degree)
-Lynch* cancers with 1 being Endometrial or Colorectal, any age

*Lynch cancers: endometrial, CRC, ovarian, stomach, brain, pancreas, small bowel, ureter/ renal pelvis, biliary tract, sebaceous adenomas

Center For Women's Health

SYMPTOM CHECKLIST FOR WOMEN

bioTE® MEDICAL

Name: _____ Date: _____

SYMPTOMS	NEVER	MILD	MODERATE	SEVERE
Please check symptoms you are experiencing				
Depressive mood				
Memory Loss				
Mental confusion				
Decreased sex drive/ libido				
Difficulty in climaxing / achieving an orgasm				
Sleep problems				
Mood changes / irritability / tension				
Migraines / severe headaches				
Bloating				
Weight gain				
Breast tenderness				
Vaginal dryness				
Hot flashes				
Night sweats				
Dry and wrinkled skin				
Hair falling out				
Feeling cold all of the time				
Joint Pain				
Swelling all over the body				