WOMEN'S HEALTH
and Menopause Center

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Amy Marcotte, M.D.
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Danielle Henzie, MA, DO
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www.whmcenter.com

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

THERE IS A $6.95 CHARGE FOR ALL RECORDS TO BE SENT ELECTRONICALLY OR A SEPARATE FEE BASED ON VOLUME OF CHART FOR A PAPER COPY

Name of patient: _____ **Date of birth:** _____

Address: _____ **Phone number:** _____

_____ **Account number:** _____

I hereby authorize Women's Health and Menopause to receive records from:

Name: _____ **Phone number:** _____

Address: _____ **Fax number:** _____

_____

The information released should include documentation from the treatment or examination for the time period of all dates of service OR from _____ **to** _____
(date) (date)

Purpose of disclosure (check one): PCP ☐ Referral ☐ Insurance ☐ Moving ☐

Transfer of care ☐ Personal Use ☐ Other _____

Type of information to disclose (check all that apply): All records ☐ Lab Results ☐

OB records ☐ Pap smear ☐ US/Mammo ☐

I hereby authorize the use or disclosure of my individually identifiable health infonnation. I understand that the infonnation I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations. All infonnation obtained regardless of the media it is kept on may include alcohol and drug use, sexually transmitted diseases, mental health treatment (except psychotherapy notes), confidential acquired immunodeficiency syndrome (AIDS) or human itnmunodeficiency virus (HIV) only if I provide my signature on this fonn. I understand that my records are protected by the Federal Confidentiality Regulations as well as the provisions of HIPPA and cannot be disclosed without my consent.,! also understand that I have the right to revoke this authorization, in writing, at any time except for any action which has already been taken. This authorization shall be in effect for I year from the date s_igned.

_____ _____ _____

Patient signature (or legal representative) **Date** **Witness signature**

PATIENT REGISTRATION FORMS

Name: ---------- **Date of Birth: _____**

Preferred name: ----------

Preferred pronoun: _____

Address: _____ **Cell#: _____**

City: _____ **Home#: _____**

State: _____ **Zip Code: _____** **SSN #: _____**

Email: _____

Relationship status: ○ **S** ○ **M** ○ **D** ○ **W**

Employment status: ○ **Full Time** ○ **Part Time** ○ **Student** ○ **Unemployed** ○ **Retired**

Emergency Contact:

Name: ---------- **Cell#: _____**

Relationship: _____

Insurance Subscriber Information:

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

Relationship: _____ **Social Security#: _____**

Primary Care Physician:

Name: _____ **Office#: _____**

Address=----------

Race (circle): American Indian, Asian, African American, Nat Hawaiian/Pacific Islander, Caucasian, Unknown, Other _____ ☐ **Declined**

Ethnicity (select one): ○ Not Hispanic or Latino ○ Hispanic or Latino Unknown ○ Declined

Communication Preferences (select all that apply):

☐ Mail ☐ Phone call ☐ Text message ☐ MyChart ☐ Declined

PRIVACY POLICY

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review carefully. We are required by law to maintain the privacy of protected health information, give you notice of our legal duties and privacy practices regarding your health information and to follow the terms of the notice currently in effect. We may use and disclose your health information for your treatment and to provide you with treatment related health care services. We may use and disclose your health information so that others may bill and receive payment for you, an insurance company or a third party for the treatment and services you received.

Signature: _____ **Date:** _____

PATIENT HISTORY FORM

Name: _____ **DOB:** _____

Preferred Name: _____

Preferred Pronoun: _____

Medication allergies: _____

Are you allergic to any of the following? ◯ Latex ◯ Idine

PLEASE **Select IF YOU HAVE ANY OF THE FOLLOWING MEDICAL CONDITIONS:**

☐ Anemia	☐ Asthma	☐ Stroke	☐ Thyroid problems
☐ Depression	☐ Anxiety	☐ Arthritis	☐ Seizures
☐ Venereal Disease	☐ Bowel Trouble	☐ Heart murmur	☐ Pneumonia
☐ Mental Illness	☐ Hypertension	☐ Heart Problems	☐ Blood Clots
☐ Kidney Problems	☐ Diabetes	☐ Migraines	☐ Osteoporosis
☐ Kidney Stones	☐ Fibroids	☐ Ovarian Cyst	☐ Endometrlosis

☐ Cancer: _____

	DATE	**WHERE**	RESULTS
PAP SMEAR			
MAMMOGRAM			
BONE DENSITY SCAN			
COLONOSCOPY			

At what age did menstruation begin? _____

What was the first day of your last menstrual period? _

If you are in menopause, at what age did you start? _____

Do you perform self-breast exams? ◯ Yes ◯ No If yes, how often? _____

Are you currently sexually active? ○ Yes ○ No

What is your sexual orientation or sexual Identity?

☐ Heterosexual/ Straight (Not Transgender) ☐ Gay

☐ Heterosexual/ Straight (Transgender) ☐ Caisexual

☐ Lesbian

Other: _____

What do you currently use for birth control? _____

PLEASE SELECT (ALL THAT APPLY) IF YOU HAVE HAD ANY OF THE FOLLOWING SURGERIES:

☐ Bladder Surgery ☐ Appendectomy ☐ Thyroidectomy ☐ BSO

☐ Breast Surgery/Mastectomy ☐ Caesarean Section ☐ Ovarian Cyst Removal ☐ D&C

☐ Tubal Ligation ☐ Hysterectomy ☐ Gallbladder ☐ LEEP

☐ Other: _____

OB/GYN HISTORY

	NUMBER
BIRTHS	
IYIISCARRIAGES	
TERMINATIONS	
LIVING CHILDREN	

FAMILY HISTORY

ILLNESS	RELATIVE (with age of onset)
☐ DIABETES	
☐ STROKE	
☐ HYPERTENSION	
☐ DRINKING PROBLEM	
☐ BREASTCANCER	
☐ OVARIAN CANCER	
☐ COLON CANCER	

SOCIAL HISTORY:

Tobacco use: ◯ Past/Date quit: __ _ Present- packs per day: ___ ◯Never

Alcohol use: ◯ Never ◯ Occasionally ◯ Regular use drinks per day: ___

Drug use: ◯ Past/Date quit: ◯Present-type:_____ ◯Never

MEDICATION LIST (with dosage):

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CREDIT CARD ON FILE AGREEMENT

Women's Health and Menopause Center has implemented a new credit card policy. Like many other practices and medical offices, we have adopted a similar policy. We kindly request our patients' guardian/guarantor for a credit card which may be used later to pay any balance that may be due on your bill. Co-pays are still due at the time of service. At registration and/or check-in, your credit card information will be obtained and kept securely until your insurance(s) have paid their portion and notifies us of the balance due, if any.

The information will be held securely until your insurance has paid their portion of the claim and notified us of any additional amount owed by the patient. At that time, we will notify you that your outstanding balance will be charged to your credit card five (5) days from the date of the notice. You may call our office if you have a question about your balance. We will send you a receipt for the charge. This "Card-on-File" program simplifies payment for you and eases the administrative burden on your provider's office. It reduces paperwork and ultimately helps lower the cost of healthcare. Our Customer Support line is available to answer any questions about the balance due. If you have any questions about the card-on-file payment method, please do not hesitate to let us know.

◯ **American Express** ◯ **Discover** ◯ **MasterCard** ◯ **Visa**

Name on Card (Print): _____

Cardholder Relationship to Patient: _____

Card Number: _____ **Exp. Date (mm/yyyy):** __ /___ **CW:** __

Please fill out information below for any person(s) you authorize this credit card for:

Patient Full Name (Print): _____ **DOB:** __ /__ /__

Patient Full Name (Print): _____ **DOB:** __ /__ /__

Patient Full Name (Print): _____ **DOB:** __ /__ /___

By signing below, I authorize Women's Health and Menopause Center to keep my signature and my credit card information securely on-file in my account and to charge my credit card for any outstanding balances when due.

Credit Card Holder's Signature: _____ Date: _____

Please check this box if you prefer not to receive a statement and would like us to bill your credit card immediately for any balances due after the processing of your insurance.

MRN: -------

Authorization and Responsibility Agreement

We invite you to discuss with us any questions regarding our services or policies. The best health services are based on a friendly, mutual understanding between provider and patient.

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Our relationship is with you, not your insurance company.

I hereby authorize my insurance company to pay directly to Women's Health and Menopause Center any professional or medical expense benefits for services rendered. If my insurance company does not pay my balance in full within 30 days, I will be responsible for contacting my carrier to inquire about the delay.

I authorize Women's Health and Menopause Center to release any information pertinent to my case to any insurance company, adjuster, and attorney involved in the case, and hereby release Women's Health and Menopause from any consequence thereof. A photocopy of this assignment shall be considered as effective and valid as the original.

I authorize Women's Health and Menopause Center to obtain a copy of my ID and insurance card for their records. I am aware that providing a copy of my insurance card does not confirm that my coverage is effective or that the services rendered will be covered by my insurance company.

_____

Signature of Patient or Responsible Party

Financial Responsibility

Our office policy requires payment in full for all services rendered at the time of the visit unless other arrangements have been made with the business manager, or current and complete insurance information is submitted. I understand that I am responsible to pay for services rendered, including reasonable attorney's fees and costs of collection in the event of default. I further understand that if a payment becomes 60 days past due, a $15 late fee will be added to the balance owed. If an account is turned over to our collection agency a 50% fee will be added to the account to cover the agency fees.

I understand it is my responsibility to know my own insurance benefits and any exclusions in my insurance policy. It is also my responsibility to provide current and accurate insurance information, including any updates and changes in coverages.

As an established patient, I understand that if I have insurance that is no longer accepted by Women's Health and Menopause Center, I have the option to continue my care as a patient but all office visit fees will be my financial responsibility, because no claims will be sent to my insurance company.

Women's Health and Menopause does not participate with any Non-MCO Medicaid Plan (Manage care) also known as "straight Medicaid." Women's Health and Menopause Center also does not accept any Medicaid plans as secondary or tertiary insurances. If you have a MCO (managed care) or straight Medicaid, you will be responsible for all deductibles, co-insurances and copays from your primary insurance.

Returned checks will be assessed a $15 fee each time it is declined by the bank. We will put an NSF check through twice. (If payment on a collection account is returned it will be accessed at a 50% fee.

Authorization to Release

I have read the financial policies contained above, and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full.

Returned checks will be assessed a $15 fee each time it is declined by the bank. We will put an NSF check through twice. (If payment on a collection account is returned it will be accessed at a 50% fee.

Patient Name: _____ **Date:** _____

Patient Signature: _____

Guarantor Signature: _____
(if patient is 17 years of age or younger)

Relationship to Patient: _____