Eastwind Women's Health

Patient Information

★ **Patient Information:** (Please print and complete fully)

Legal Name: _____
(Last) (First) (Middle)

Address: _____
(Street Address) (City) (State) (Zip)

SS # (required): _____ Birth Date: _____ Age: _____

Marital Status (circle one): Single Married Widowed Divorced Partner

Phone: Home:_____ Cell: _____ Work: _____

Do we have your permission to leave a message (circle one): Yes No

Email: _____

Employer: _____ Occupation: _____

★ **Emergency Contact:**

Name:_____ Relationship:_____

Emergency Contact Phone:_____

★ **Primary Care Physician:** _____ Phone: _____

★ **Medical Insurance Information: (Must present insurance card at each visit)**
(It is the patient's responsibility to determine coverage/ benefits at the time of service)

Do you have insurance?(circle one): Yes No

Primary Insurance:_____
Subscriber Name: _____ Subscribers D.O.B: _____
Relationship to patient: _____

Secondary Insurance:
Subscriber Name: _____ Subscribers D.O.B: _____
Relationship to patient: _____

Consent to Medical Care and Treatment: While at Eastwind Women's Health I Give consent for all medical care, any tests and examinations needed. I will not hold Eastwind Women's Health or any person responsible for the results if I refuse medical treatment or advice. This consent will be valid for one year unless otherwise indicated in writing by either party.

Signature:_____ Date:_____

Eastwind Women's Health

★ **Release of Information:**

I understand that Eastwind Women's Health may use or release my medical/ health information for the following reasons as needed:

- Insurance information, billing and payment
- Release to other healthcare providers for billing, payment, referrals and discharge planning
- Quality improvement reviews
- Medicare, Medicaid and other government programs
- Employer, if injured
- Public health reporting
- Legal, regulatory and accreditation agencies
- Eastwind Women's Health may receive or release my health information, whether written, verbal, fax, or electronic using secured internet websites.

★ **Acknowledgement of Privacy Practices:**

Option 1:
_____ I was offered a copy of the Notice of Privacy Practices, but did not want it.

Option 2:
_____ I have received a copy of Eastwind Women's Health Notice of Privacy Practices.

I understand I have a right to keep my medical information private.
If you would like someone (spouse, sister, brother, son, daughter, etc.) to have access to your medical information please fill in the blanks below:

I, _____, hereby allow Eastwind Women's Health, to discuss my medical

information with _____.
Name Relationship

★ **Payment and Financial Responsibility:**

I hereby authorize and/ or assign my Medicare and/or my insurance benefits to be paid directly to Eastwind Women's Health. I realize I am responsible to pay non- covered services as well as any deductibles, copays or coinsurance. I am aware that all unpaid balances and copays are due at the time of my visit. I certify that the information given to me by the practice, in applying for under Medicare and/ or insurance coverage or other protection is correct and complete. I authorize any holder of medical information about me to release to Medicare and/ or the insurance company or its agents, any information needed to determine the benefits payable to related services. I consent to any request for review or appeal by Eastwind Women's Health, to challenge a determination of benefits made by a third party payer/ insurer. This assignment will remain in effect until revoked by me if writing. A photocopy of this assignment is considered to be as valid as the original. If you are a self pay patient any quotes provided are strictly estimates.

Print Name: _____ Date of Birth:_____

Signature: _____ Date:_____

Eastwind Women's Health

Eastwind Women's Health Financial Policy

Welcome to Eastwind Women's Health. In order for our medical staff to able able to deliver the quality of care that you are accustomed to, we have established our financial policies. The following is a list of guidelines that are necessary to continue to provide high- quality care and make your visit as pleasant as possible.

Please read ALL information and acknowledge by signing below:

1. If you have a change of address, name, telephone number or insurance, please notify the receptionist.
2. We ask that you present a copy of your insurance card at each visit. It is your responsibility to provide us with the correct information to bill your insurance.
3. We will collect your co-payment at the time of your visit. If you have a balance after an insurance payment from a previous visit, we will also ask for that payment. We accept checks, cash and all major credit cards.
4. If we do not participate within network of your insurance company, you will be expected to make payment in full at the time the service is rendered.
5. If your insurance denies our charges, does not pay us in a timely manner, or if your account becomes delinquent, we reserve the right to refer your account to a collection agency and report your account to the credit bureau.
6. HMO-PPO: If we participate with your plan, we will bill your insurance for you. Your co-payment will be collected at the time of the visit. If insurance requires a referral from your PCP. It is your responsibility to obtain it day of the visit.
7. SELF-PAY: Patients with no insurance will be expected to pay in full at the time of the visit.
8. Your insurance is a contract between you, your employer, and the insurance company. It's very important that you understand the provisions of your policy. We cannot guarantee payment of all claims. If your insurance company only pays a portion of the bill or rejects your claim, any contract or explanation should be made to you, their policy holder. Reduction of rejection of your claim by your insurance does not relieve you of your financial obligation.

Remember, whether you do or do not have insurance, you are ultimately financially responsible for your payment of the charges. If you have any questions regarding our financial policy, please contact our billing department at 614-890-1914, ext 3.

I have read and have a full understanding of the financial policy of Eastwind Women's Health.

Print Name_____ Date of Birth: _____

Signature: _____ Date: _____

Eastwind Women's Health

Risk Assessment Questionnaire

Patient Name: _____ Physician: _____

Date of Birth: _____ Age: _____ Today's Date _____

Instructions: Your physician NEEDS this information to perform an accurate assessment of your medical and cancer risks. Answer the questions by circle YES or NO. If you circle YES, please provide the relationship of the family member with the illness/ cancer AND their age at diagnosis. **Please include:** Mother/ Father/ Sisters/ Brothers/ Children/ Aunts/ Uncles/ Grandparents/ Nieces / Nephews/ Cousins/ Great- Grandparents

Questions	Yes	No	Age when Diagnosed	Mother's Side (Included Age)	Father's Side (Include Age)
Have you or any relatives been diagnosed with breast cancer **before the age of 50?**	Y	N			
Have you or any relatives ever been diagnosed with ovarian cancer at any age?	Y	N			
Do you have **two or more** relatives diagnosed with breast cancer? (please list who & ages)	Y	N			
Any male breast cancer in your family?	Y	N			
Is there any pancreatic cancer in your family?	Y	N			
Is there a family member with known BRCA?	Y	N			
Have you or any relatives been diagnosed with Colon or Rectal cancer **before age 50?**	Y	N			
Have you or any relatives been diagnosed with Uterine (endometrial) cancer **before the age of 50?**	Y	N			
Do you have **two or more** relatives diagnosed with the following cancers: colon, uterine, overvian, stomach, small bowel, brain, kidney/ urinary, ureter, renal- pelvis? (please list who & age)	Y	N			

Are you of Jewish (Ashkenazi) descent? YES or NO

Is there any other cancer that has been diagnosed in your family if not listed above? If yes, please explain _____

Patient Signature: _____ Date: _____

Eastwind Women's Health

Medical History

Name: _____ Date of Birth: _____

Reason you are being seen at our office today:
_____
_____

Kind & Date of all surgical operations:
*_____
*_____
*_____
*_____

Name & Date of serious illness/ hospitalizations
*_____
*_____
*_____

Medications you are presently taking:
*_____
*_____
*_____
*_____

List of all drug allergies
*_____
*_____
*_____
*_____

Dates of last 2 menstrual periods
*_____
*_____

What type of birth control are you taking (if any):
*_____

Pregnancy:
Number of Pregnancies_____
Number of living children: _____
Miscarriages: _____
Abortions:_____

Has anyone in your immediate family ever had?
____ Cancer ____ genetic disorders
____ diabetes ____ seizures ____ stroke
____ heart trouble ____ high blood pressure

Date of last pap smear: _____

Check any of the following that apply:

___ frequent headaches	___ trouble with eyes or vision	___ convulsions or paralysis
___ dizzy spells	___ shortness of breath	___ recurrent chest pain
___ asthma	___ heart murmur	___ easy bruising or bleeding
___ rheumatic fever	___ emphysema	___ blood clot in vein
___ vomiting blood	___ blood in stool	___ persistent or severe abdominal pain
___ recurrent diarrhea	___ persistent nausea/ vomiting	___ drinking problems
___ presently smoking	___ aching or painful joints	___ hernia
___ bloody urine	___ inability to control urine	___ recurrent bladder infections
___ burning with urination	___ urinary frequency	___ diabetes
___ thyroid problems	___ high blood pressure	___ blood transfusion
___ hepatitis (liver disease)	___ jaundice	___ recent weight change (involuntarily)
___ emotional problems	___ sexual difficulties	___ venereal disease
___ drugs (LSD, heroin, ect)	___ coughing up blood	___ desire psychiatric help

I authorize the release of information necessary to process insurance claims for my medical care with Eastwind Women's Health. I authorize payment of medical benefits to Eastwind Women's Health for services rendered. I am aware that although I have insurance, I am personally responsible for all charger.

Patient Signature: _____ Date: _____