PLEASE PRINT ALL INFORMATION

THIS FORM MUST BE FILL OUT **COMPLETELY** FOR INSURANCE PURPOSES

PATIENT INFORMATION

NAME_____ DATE OF BIRTH_____

ADDRESS _____

HOME PHONE _____CELL NUMBER _____

Email ADDRESS_____ MARITAL STATUS_____

EMPLOYER _____WORK NUMBER _____

SOCIAL SECURITY NUMBER _____

~RACE (CIRCLE ONE) 1. ASIAN 2. AFRI CAN AMERICAN 3. WHITE 4. HAWAIIAN/PACIFIC ISLAND 5. OTHER

~ETHNITICITY (CIRCLE ONE) 1. NOT HISPANIC OR LATINO 2. ASIAN-INDIAN 3. HISPANIC OR LATINO 4. OTHER

~EMERGENCY CONTACT NAME _____ PHONE NUMBER _____

~PRIVACY CONTACT NAME_____

RELATIONSHIP_____DOB:_____

~PHARMACY NAME/address _____

~PRIMARY CARE PHYSICIAN _____

MEDICAL INSURANCE INFORMATION

PLEASE PRESENT INSURANCE CARD AT EACH VISIT

If you do not have a current insurance card you will be responsible for paying all charges at the time of service

PRIMARY INSURANCE

Insurance company Name: _____

ID number: _____ Group number _____

Subscriber Name: _____DOB_____ SS #_____

SECONDARY INSURANCE

Insurance company Name: _____

ID Number: _____Group Number: _____

Subscriber Name: _____DOB_____SS#_____

IF PATIENT IS A MINOR WHO IS RESPONSIBLE FOR CHARGES:

NAME _____ RELATIONSHIP_____ DOB_____

SOCIAL SECURITY NUMBER_____

WOMEN'S HEALTH PARTNERS FINANCIAL POLICY

Thank you for choosing us as your women's health care provider. We are committed to providing you with the best possible medical care. The following information is provided to avoid any misunderstanding concerning payment for services provided by our office.

1). Please bring your current insurance card to every visit. We may need to reschedule your appointment if not provided.
2). Please be prepared to pay your co-pay at each visit. Payment can be made by cash, check MasterCard, Visa or Discover.
3). If you *do not* have insurance coverage or if you are insured by a company with which we are not contracted, payment in full is expected at time of service unless prior payment arrangements have been made. Promissory Note available.
4). All balances billed are due upon receipt. Promissory Note available.
5). There is a $30.00 fee on all returned checks.
6). There is a $25.00 fee to copy any or all medical records.
7). If you miss or no show for three (3) appointments you may be dismissed from the practice.

**I understand and certify that I am financially responsible for all health care charges due to the physician that might be paid to me directly by my insurance carrier, as well as deductibles, co insurance amounts or charges for non-covered services provided to me

Please let us know if you have any questions or concerns.

By signing below, I acknowledge that I understand and agree with the above written policies. I understand that ***ultimately*** I am responsible for payment of charges.

SIGNATURE OF PATIENT OR GUARDIAN – DATE

COMMERCIAL INSURANCE ADVANCED BENEFICIARY NOTICE (ABN)

You are receiving this notice because your insurance company may not pay for all the services that you receive during your visit.

I hereby assign payment of any and all benefits to be made directly to WHP(Women's Health Partners/Carolyn Hixson, MD) and authorize the release of any information necessary to process claims. I understand that I am responsible for any and all charges not covered by insurance.

____ YES I want to receive these services. IF my commercial insurance carrier denies payment, I am completely responsible for payment in full.

____ NO I have decided not to receive these services.

By signing this notice you agree to take financial responsibility for the cost of the supplies and services listed above should your insurance company deny coverage for the visit.

Patient Name: _____ Date: _____

Billing Contact Consent

I authorize my healthcare provider and/or any entity authorized by my healthcare provider, including those using automated dialing systems, automated messages, email, text messaging or other electronic communication to contact me for any reason by using any telephone number, email address and/or mailing address provided.

_____ _____/_____/_____

Signature Date

Medication History Consent

I authorize my healthcare provider to upload my prescription history electronically with Surescripts.

_____/_____/_____

Signature Date

Women's Health Partners

Patients Name: _____

RECEIPT OF NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

I hereby acknowledge that on this date_____ I received the Notice of Privacy Practices of this facility which sets forth the ways in which my personal health information may be used or disclosed by this practice, and outlines my rights with respect to such information.

*WHP (Women's Health Partners) Dr. Hixson is a partner with OhioHealth Group which is considered an Organized Healthcare Arrangement.

_____ _____

Signature/Guardian Signature **Date**

HIPPA GUIDE

Why you are receiving a Notice from your doctors and health plan

Your health care provider and health plan must give you a notice that tells you how they may use and share your health information and how you can exercise your health privacy rights. In most cases, you should get this notice on your first visit to a provider or in the mail from your health insurer, and you can ask for a copy at any time. The provider or health plan cannot use or disclose information in a way that is not consistent with their notice.

- The law does not require you to sign the "acknowledgement of receipt of the notice."
- Signing does not mean that you have agreed to any special uses or disclosures of your health records.
- Refusing to sign the acknowledgement does not prevent the entity from using or disclosing health information as the Rule permits it to do.
- If you refuse to sign the acknowledgement, the provider must keep a record that they failed to obtain your acknowledgement.

Notice of Privacy Practices

Keeping Your Personal Health Information (PHI) Private

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Women's Health Partners and its employees, and many other healthcare professionals, work together to provide the best care to our patients. As allowed by law, patient health information is used and shared in order to provide for treatment, arrange for payment for treatment, and to conduct our healthcare operations. The purpose of this Notice is to tell you how we will use and share your health information and how you can find out more information about our privacy practices.

I. We Have a Legal Duty to Protect Your Health Information
We are required by law to maintain the privacy of our patients' health information and to provide our patients with information concerning our organizations' privacy practices. This includes your past, present or future health information (your condition, care provided to you, or payment information). We are required to abide by the terms of this Notice so long as it remains in effect. We reserve the right to change the terms of this Notice and to make a new Notice effective for all personal health information that we maintain. You may receive a copy of any revised Notice by contacting the Privacy Officer, Women's Health Partners, 4141 North Hampton Drive, Suite 101, Powell, Ohio 43065.

II. We May Use and Disclose (Share) Your Health Information

1. **For Treatment/Care.** We may use and share your health information for your treatment or care.
   For example:
   - Doctors, nurses, and other staff involved in your care will use information in your medical record so that we can provide you with the best care.
   - If you are being treated for a knee injury, we may share your health information with the Physical Therapy staff so they can help plan your care.
   - We may also share your health information with another health care facility or professional not associated with us but who will be providing treatment or care to you. A specific example, if you leave this healthcare facility to receive home healthcare, we may share your health information with that home health care agency so that your treatment and care plan can be prepared for you.

2. **For Payment of Your Treatment.** We may use and share your health information if needed for payment purposes. For example:
   - We may share information about your tests and care with your insurance company to arrange payment for services provided to you.
   - We may use your information to prepare a bill to send to you or to the person responsible for your payment.
   - We may share your health information with our business partners that help us with things like billing and claims. These businesses MUST protect the privacy of your information.
   - For payment purposes, we may share your health information with other healthcare professionals who have treated you or provided services to you, even though they may not be associated with us.

3. **For Healthcare Operations.** We may use and share your health information, as necessary and as permitted by law, to help improve care and operate the office (such as improving clinical care, staff evaluations, managing our business, auditing, legal services, accreditation and licensing). For example:
   - We may use and share your health information to evaluate the care the staff provides.
   - We may need to share health information with our business partners that help us with our healthcare operations. These businesses MUST protect the privacy of your information.
   - We may also share your health information with other health-care professionals, facilities and health plans to help them improve their care and operations, but only if they also have a patient-relationship with you.

4. **For Appointment Reminders and Health-related Benefits or Services.** We may use health information to send appointment reminders or test results.

5. **Health Products and Services.** We may use your health information to let you know about our health products and services, those necessary for your care, to tell you of new products and services we offer and to give you general health and wellness information.

6. **For Workers' Compensation.** We may share your health information with workers' compensation agencies if needed for a benefit determination.

7. **When services are requested by your employer.** We may share your health information with your employer when we have provided care to you at the request of your employer. In most cases, you will get a notice that information has been sent to your employer.

8. **For Some Government Functions.** We may share your health information if needed:
   - If you are a veteran or in the military.
   - For national security or intelligence activities, such as protecting the President of the United States or conducting intelligence operations.

9. **To Avoid Harm.** We may share health information to law enforcement or safety staff in order to avoid a serious threat to the health or safety of one person or the public.

10. **For Research.** We may share your health information for research when it is approved by an Institutional Review Board with special rules to ensure privacy.

11. **For Purposes of Organ Donation.** We may share your health information if needed to arrange for organ or tissue donation from you or to give a transplant to you.

12. **For Health Oversight Activities.** By law, we must share your health information as needed to a government agency doing audits, investigations, and civil or criminal proceedings. For example:
    - We will share information to help the government when it investigates a healthcare provider or organization.

13. **For Public Health Activities.** We may share your health information for public health activities, such as reporting diseases, injuries, births, deaths, and looking into disease outbreaks. For deceased patients, by law and only if needed, we must share your health information with coroners and funeral directors.

14. **For Legal Cases or Law Enforcement** (at the federal, state and local level). We may share your health information as needed:
    - To report wounds, injuries and crimes.
    - If we suspect child abuse or neglect.
    - If we believe you are a victim of abuse, neglect, or domestic violence.
    - To the Food and Drug Administration to report medicine adverse reactions, product defects, or product recalls.
    - Under court order.
      Ohio law requires that we obtain your permission in many instances before disclosing information about:
    - performance or results of an HIV test or diagnoses of AIDS or an AIDS-related condition,
    - drug or alcohol treatment you have received in a drug or alcohol treatment program,
    - mental health services you may have received.

III. You Have the Opportunity to Object ("Opt Out") to the Following Uses and Disclosures:

1. **Family and Friends Helping In Your Care.** With your approval, we may share your health information with your family, friends, or other caregivers that help with your care or payment of your care. If you are not available or are incapacitated or facing a medical emergency, we may share your information if we determine that doing so is in your best interests. We may share health information to an agency that is helping in disaster relief efforts so that they may find your family or caregiver.

IV. All Other Uses and Disclosures Need Your Prior Written Authorization. In any situation not mentioned in section II or III, we will ask for your written authorization before using or sharing your health information. If you sign an authorization form, you can later cancel that authorization (in writing) to stop any future uses.

V. Your Rights Regarding Your Health Information

1. **The Right to Access Your Own Health Information.** You have the right to copy and/or inspect most of your health information that we keep on your behalf.
   - *All requests to copy and/or inspect your health information must be made in writing and signed by you or your legal representative.* You may get an access request form from our Office Manager.
   - If there is a cost, we will tell you in advance. We will charge you for copying the health information, postage (if mailed) and/or for a summary or explanation of the health information.

2. **The Right to Request Amendments to your Health Information.** You have the right to request amendments (changes) to your health information if you believe the information is not accurate.
   - You must make a written request and state your reason for amending your health information. Contact our Office Manager for an amendment form.
   - We are not obligated to agree to the request, but we will give each request careful consideration. If we approve your request, we will place the amendment form in your medical record, tell you that we have done it, and tell others that need to know about the change.
   - We may deny your request if the information is accurate and complete as written, or, was not created by us. If your request is denied, we will tell you, in writing, with the reason(s) for the denial. We will explain your right to file a written statement of disagreement with the denial.

3. **The Right to an Accounting of Certain Disclosures of Your Health Information.** You have the right to receive an accounting of when we shared your health information and to whom.

   The list will include:
   - the date and to whom (with the address, if known) health information was disclosed,
   - the reason and type of health information shared.

   This list will not include disclosures:
   - made for treatment, payment, healthcare operations, or directly to you or to your family,
   - that you have already authorized in writing,
   - for national security purposes,
   - for corrections or law enforcement staff, or
   - occuring before April 14, 2003.

   Written requests must be signed by you or your legal representative. Contact the Office Manager for an accounting request form.
   - The first list in any 12-month period is free. You will be charged for each extra list you request in the same 12-month period.

4. **The Right to Ask For Limits on Using and Sharing Your Health Information.** You have the right to request that we limit how we use and share your health information for treatment, payment, or healthcare operations. You may not limit the uses that we are allowed to do by law.
   - We are not obligated to agree to your request but we will try to abide by your request when appropriate.
   - We have the right to end an agreed-to limitation if we believe that ending it is needed or that the limit will be hard to complete. You will be informed.
   - You can end an agreed-to limitation by sending a written termination notice (signed by you or your legal representative) to our Office Manager.

5. **The Right to Choose How We Send Health Information to You.** You have the right to request that we send information on you to a different address or in a different method (e.g. via phone, fax). We must agree to your request if it is reasonable and if it can be easily done.

VI. How to Complain About Our Privacy Practices.

If you feel your privacy rights have been violated, you may file a complaint with:
- Our Privacy Officer. The complaint must be in writing and mailed to Women's Health Partners Privacy Officer, 4141 North Hampton Drive, Suite 101, Powell, Ohio 43065.
- You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services in Washington D.C. within 180 days of a violation of your rights. We will take no retaliation if you file a complaint.

For More Information About This Notice. If you have questions or need further help with this Notice, you may contact or write the Women's Health Partners Privacy Officer, 4141 North Hampton Drive, Suite 101, Powell, Ohio 43065.

As a patient you have the right to get a paper copy of this Notice of Privacy Practices, even if you have asked for a copy by e-mail or other means.

VII. Acknowledgement of Receipt of Notice.
You will be asked to sign an acknowledgement form that you received this Notice of Privacy Practices.

VIII. Effective Date
This Notice of Privacy Practices is effective April 14, 2003.

Women's Health Partners

MEDICATION HISTORY

Current Medication List: ___NONE
(include all over the counter medications & supplements)

1._____ 2._____
3._____ 4._____
5._____ 6._____
7._____ 8._____
9._____ 10._____

Medication Needing Refilled Today: ___NONE

1._____ 2._____
3._____ 4._____

Drug Allergies: ___NONE

Medication:_____Reaction:_____
Medication:_____Reaction:_____
Medication: _____Reaction:_____

Recent Surgeries: ___NONE
(within last 24 months)

_____
_____
_____

NAME: _____

DOB: _____ **Today's Date:** _____

CAROLYN HIXSON, MD **PATIENT MEDICAL HISTORY FORM** **Appointment Date** _____

Name:_____ **DOB:** _____

Past Medical History: (circle) Glaucoma Cataracts Thyroid Diabetes Kidney Stone Polycystic Kidney Disease Renal Disease/Failure Hypertension Heart Attack Coronary Artery Disease Congestive Heart Failure Arrhythmia Phlebitis/DVT Stroke Embolus (blood clot) Bleeding Disorder Clotting Disorder Anemia Asthma Emphysema COPD TB Arthritis Fibromyalgia Osteopenia Osteoporosis Irritable Bowel Syndrome (IBS) Gallbladder Ulcers Liver Disease/Cirrhosis Ulcerative Colitis/Cohn's Hepatitis Seizures/Epilepsy Migraines Alzheimer's Alcoholism Drug Addiction Anxiety Depression Panic Disorder Bipolar

Other, Specify _____

_____

Cancer, Type & Date Diagnosed _____

_____

Menstrual History: **Date Last Period Began:**_____ **# of days between periods:**_____ **Duration:**_____

Age at first period _____ **Do you have a period every month:** YES or NO **Current method of Birth Control** _____

Is your period normally: Light Medium Heavy Clots **Cramps:** YES or NO **History of Abnormal PAP Smear:** YES or NO

History of: (circle) Yeast BV Trichomonas Chlamydia Herpes Gonorrhea HPV HIV Genital Warts Hepatitis PID

Date of last Mammogram _____ **Date of last DEXA** _____ **Date of last Colonoscopy** _____

Menopausal History: **If menopausal, age menopause began:** _____ **Hot Flashes:** Yes or No **Night Sweats:** Yes or No

Hormone therapy: Yes or No **Other Treatment:**_____

OB/GYN History: # of times pregnant: _____ Premature Babies: # _____ Abortions: #_____ Miscarriages: #_____

Ectopic: # _____ Still Birth: # _____ C-Sections: # _____ Vaginal Deliveries: # _____

Social History: **Occupation** _____ **Marital Status:** (circle) Married Single Divorced Separated Widow

Education Level: (circle) less than 8th grade 8 9 10 11 12 some college 2 yr college 4 yr college post graduate

General Stress Level: (circle) Low Medium High **Exercise Level:** (circle) None Occasional Moderate Heavy

Illicit Drugs: Yes or No **if YES** which drugs _____

Smoke: Yes or No or Quit **if YES** how much _____ for how long _____ **if Quit** when _____

Alcohol: (circle) None Occasional Moderate Heavy **Have you ever felt the need to cut down on drinking:** YES or NO

Sexually Active: YES or NO or VIRGIN **Sexual Orientation:** Heterosexual Homosexual Bisexual

Number of Sexual Partners (lifetime) _____

Any changes in your relationship: YES or NO **Do you feel safe in your relationship:** YES or NO.

Surgical History: 1._____Yr._____ 2._____ Yr. _____ 3._____ Yr._____

4._____ Yr. 5._____ Yr. 6._____ Yr.

Family History: Please list your family members who have had any of the following using the following abbreviations:

M=Mother, **F**=Father, **S**=Sister, **B**=Brother, **MGM**=Mother's mother, **MGF**=Mother's father, **MA**=Mother's sister

PGM=Father's mother, **PGF**=Father's father, **PA**=Father's sister

_____Breast Cancer _____Heart Attack _____Hyperthyroidism _____Hypothyroidism _____Anemia

_____Ovarian Cancer _____Stroke _____Depression _____Respiratory Disease _____Anxiety

_____Uterine Cancer _____High Cholesterol _____Liver Disease _____High Blood Pressure

_____Cervical Cancer _____Colon Cancer _____Diabetes _____Blood Clots in Legs _____Heart Problems

_____Blood Clots in Lungs _____Other Cancers_____

SYMPTOM REVIEW PATIENT NAME_____ DOB_____ TODAY'S DATE_____

Please check if you CURRENTLY have any of the following:

GYN

__breast complaints (specify)

_____

__pain/bleeding w/intercourse
__pelvic pain
__urinary incontinence
__vaginal discharge/irritation/itching

GENERAL

Recent illness (specify)

_____

__loss of appetite
__fatigue
__fever
__unexplained weight loss

EYES

__cataracts
__glaucoma

CARDIOVASCULAR

__arrhythmia
__chest pain
__palpitations
__shortness of breath

GI

__abdominal pain
__nausea
__vomiting
__constipation
__diarrhea

RESPIRTORY

__asthma
__cough
__difficulty breathing

MUSCULAR SKELETAL

__back pain
__joint pain
__muscle weakness
__muscle pain

NEUROLOGIC

__dizziness
__headache
__seizures
__fainting spells

PSYCHIATRIC

__alcohol abuse
__anxiety
__depression
__drug abuse

ENDOCRINE

__diabetic, type 1
__diabetic, type 2
__increased/abnormal hair growth
__low thyroid

HEMATOGICAL

__anemia
__enlarged lymph nodes
__blood clots
__phlebitis
__DVT
__pulmonary embolism

SKIN

__eczema
__rash
__sores
__skin cancer

CANCER GENETIC SCREEN

YOUR PERSONAL HISTORY:

Y/N Breast cancer at age 50 or younger
Y/N Triple negative breast cancer
Y/N Ovarian cancer
Y/N Breast cancer in both breasts or multiple breast cancers
Y/N Uterine cancer @ age 50 or younger
Y/N Colorectal cancer @ age 50 or younger
Y/N Multiple different types of cancer: breast, ovarian, pancreatic, melanoma, uterine, thyroid, sarcoma, colorectal, small bowel or stomach
Y/N Ten or more colorectal polyps in a lifetime

FAMILY HISTORY:

Y/N Male breast cancer
Y/N Ovarian cancer
Y/N Ashkenazi Jewish ancestry & personal or family history of breast or ovarian cancer

FAMILY HISTORY ***The following history on the SAME SIDE of the family:***

Y/N Two or more relative's w/breast cancer
Y/N Two or more relative's w/uterine or colorectal cancers
Y/N Two or more relatives w/any combination of these cancers:
Breast, ovarian, prostate, pancreatic, male breast, melanoma, uterine, thyroid, sarcoma, colorectal, small bowel, or stomach

All

NO SHOWS

Will be subject

To a $25.00 fee

(cancellation within 24 hours of appointment time could be considered a no show)