Compassion Women's Clinic

2915 Cypress Road; Suite A
Arkadelphia, AR 71923

Phone: 870-403-0299
Fax: 870-403-0900

Patient Information	Spouse/Parent Information
First Name: MI: Last:	First Name: MI: Last:
Address:	Relationship:
City: State: Zip:	Address:
Phone: Cell:	City: State: Zip:
Email:	Phone: Cell:
Date of Birth:	Date of Birth:
Age: Sex:	Social Security Number:
Marital Status:	Employer:
Social Security Number:	Work Phone:
Employer:	**Emergency Contact**
Work Phone:	Name:
Pharmacy:	Relationship:
Primary Physician:	Phone: Cell:

Insurance Information

WE WILL NEED A COPY OF YOUR CARD(S) FOR OUR FILES

☐ No Insurance/Private Pay ☐ Group Insurance ☐ Individual Policy ☐ Work. Comp. ☐ Auto Insurance

Primary Insurance:	**Secondary Insurance:**
Mail Claims To:	Mail Claims To:
Group No.: ID No.:	Group No.: ID No.:
Policy Holder's Name:	Policy Holder's Name:
Address:	Address:
Policy Holder's Date of Birth:	Policy Holder's Date of Birth:
Policy Holder's Soc. Sec.#:	Policy Holder's Soc. Sec.#:
Policy Holder's Employer:	Policy Holder's Employer:

Financial Policy

Our practice is committed to providing the best treatment for patients and we charge what is usual and customary for our area. It is customary to pay for services when rendered unless prior arrangements have been made. Your insurance coverage is a contract between you and your insurance company. We will assist you to receive maximum benefits, but you are ultimately responsible for all charges. If we accept your insurance, you are expected to pay any non-covered charges, co-pays or deductibles at the time of service. It is ultimately the patient's responsibility for payment regardless of insurance coverage.

Authorization, Consent and Acknowledgment

I hereby authorize my insurance benefits to be paid directly to Compassion Women's Clinic (CWC). I consent to the use or disclosure of my protected health information by CWC for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills or to conduct healthcare operations of CWC. I have the right to revoke this consent in writing at any time, except to the extent that CWC has taken action in reliance on this consent. I understand I have the right to review CWC's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices for CWC has been provided to me.

Signature of Patient or Guardian _____ Date _____

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Patient History Information

Patient Name_____ Date of Birth _____

Marital Status:_____ Father of Baby:_____

Emergency Contact/Relation to Patient:_____

Emergency Contact Phone number:_____

ALLERGIES: Medication_____ Other Allergies_____

CURRENT MEDICATIONS: (include all prescription meds, vitamins & over-the-counter meds)

_____

_____

MEDICAL HISTORY: (circle all that apply)

Diabetes	Hypertension	Heart Disease	Autoimmune Disorder
Kidney Disease	Recurrent UTI	Psychiatric	Varicosities/Phlebitis
Thyroid dysfunction	Trauma/Violence	Blood Transfusion	D (RH) Sensitized
Breast Disease	Abnormal Pap	Uterine Anomaly	Infertility
GYN surgery	Anesthesia complications	Pulmonary (TB,Asthma)	
Other:			

SURGICAL HISTORY:

_____

_____

Family History: Are you adopted? ___Yes ___No

Please indicate which family members have a history of the following medical conditions using **F** (Father), **M**(Mother),**B**(Brother), **S**(Sister), **G**(Grandparent):

Diabetes ___	Anesthesia problems ___	Ovarian cancer ___
Heart disease ___	Drug/Alcohol problems ___	Blood clots ___
Stroke (before age 50)___	Osteoporosis ___	Other cancers (list location in body)
High cholesterol ___	Depression ___	_____
Bleeding problems ___	Breast cancer ___	

Have you experienced any of the following symptoms in the past year? (Please circle all that apply):

Frequent headache/migraines	Loss of appetite	Mood swings
Bowel problems / pain	Weight changes	Diet changes
Abdominal pain	Menstrual cycle changes	Sleep disturbances
Breast discharge	Breast lump	Breast pain
Sexually transmitted disease	Vaginal infection/discharge	Marital / Sexual problems
Hot flashes	Vaginal dryness	Urinary incontinence
Frequency of urination	Painful urination	
Depression	Pain with intercourse	

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Menstrual History
First day of last period_____Age period began _____
# of days between periods_____ # of days of flow_____
pads/tampons per day_____
Bleeding between periods?_____ Problems with menstruation?_____
Cramps?_____ If so, mild, moderate, severe (circle)

Obstetrical History:
Total # of pregnancies_____ # Full-term pregnancies_____
Miscarriages_____ # Premature deliveries_____ # Elective abortions_____
Living children_____ Weight of largest infant_____

Complications: Circle all that apply
Diabetes Hypertension Preeclampsia/Eclampsia Preterm Labor

Past Pregnancies									
Date Mo/ Yr	GA Weeks	Hours in Labor	Birth Weight	Sex	*Type of Delivery	Anesthesia	Place	Preterm Y/N	Complications

*Please include all vaginal deliveries, c-sections, spontaneous miscarriages, D&C's, and elective abortions. Specify type under "Type of Delivery."

Gynecological History:
Sexual partner (circle)
male female both Total number of partners:_____
Any problems with sexual relations?_____
Date of last pap smear:_____ Abnormal/Normal (circle)
History of Abnormal pap smear?___ Date:_____ Treatment:_____
Do you have any concerns of being exposed to STDs? Yes No
Circle any previous infections: Chlamydia Gonorrhea Syphilis Trichomonas
Bacterial vaginosis Condyloma (genital warts) Herpes Other _____

Were you on birth control at the time of conception?_____ If yes, what type? _____

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Social History:
Regular exercise: _____Yes_____No Amount per week:_____
Wear seatbelts: (circle) sometimes always never
Have you ever been sexually, physically or emotionally abused?_____ If yes, is this abuse going on now?_____

Do you drink alcohol? _____ # of drinks per day prior to pregnancy_____ Any alcohol use since last menstrual period?_____
Caffeine (coffee/tea/soda): _____ # of drinks per day_____
Tobacco use?_____type:_____ amount/day_____
Are you interested in quitting? ____Yes____No
Drug use: _____Yes_____No If yes, what type and date of last use_____

Genetics Screening: (Include patient, baby's father, and anyone in either family)

ITEM	Y	N	ITEM	Y	N
Patient's age is greater than 35 y/o			Cystic Fibrosis		
Thalassemia			Huntington chorea		
Neural tube defects (meningomyelocele, spina bifida, or anencephaly			Recurrent Pregnancy Loss or Stillbirth		
Congential heart defects			Mental retardation/Autism		
Down Syndrome			Fragile X		
Tay-Sachs			Other inherited genetic or chromosomal disorders		
Sickle cell disease or trait			Maternal metabolic disorder-ex: insulin-dependent diabetes, PKU		
Hemophilia			Patient or baby's father had a child with birth defect not listed above.		
Muscular dystrophy			Medications/Street drugs/Alcohol since last menstrual period		
Any Other					

This information is strictly confidential.

Thank you for taking the time to complete this form!

Reviewed by provider: Initial _____ Date _____

NOTICE OF PRIVACY PRACTICES

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.

To Our Patients: The physicians and staff of Compassion Women's Clinic *have always been committed to the absolute protection of every patient's health information. The Health Insurance Portability and Accountability Act, requires that we provide notice to each of our patients of how this information is used.*

We safeguard information about your health and person (Protected Health Information, "PHI"). We collect information from you and store it in a medical record, which may be electronically stored on computer. Our medical record charts are stored in a secure area and are available only to designated staff and only for specific reasons. If your record is computerized, we use security measures to protect it.

How We May Use and Disclose Your Protected Health Information.
We use your PHI in many ways to help in treatment, payment and clinic operations. Some examples include:

- Sending you an appointment reminder
- Obtaining your medical history and treatment and recording it in your chart
- Phoning in prescriptions
- Consulting a specialist about your care
- Providing a specialist with medical records
- Providing your PHI to an Emergency Room or Hospital
- Obtaining approval/payment from your health insurer(s) for treatment, tests or equipment
- We may use your PHI to create bills we submit to the insurance company
- Notifying you of test results
- Notifying family members upon your hospital admission
- Discuss your care with person responsible of taking care of you
- To provide treatment to you in the event there is a language or communication barrier

Our business associates that may have access to PHI are required to sign a written agreement protecting any use or disclosure of your PHI, in order to protect your privacy. For example, our medical record copying services, medical waste disposal services and transcriptionist services.

We may be required by law to use or share your PHI, without your written authorization, for the following:

- When required by federal, state and local law
- Public Health activities for reporting requirements (deaths, child abuse, domestic violence, gunshots, communicable disease, infectious disease control, Food and Drug Administration (FDA) compliance/reporting adverse events, product defects/recall, biological product defects, tracking FDA related products, etc.)
- Reporting victims of abuse, neglect or domestic violence
- Health oversight activities (audits, investigations and inspections)
- Judicial proceedings (valid Court Orders)
- Appropriate law enforcement requests
- Deceased person information (Coroners, Medical Examiners, Funeral Directors)
- Organ and tissue donation
- Medical Research

- Emergencies or to avert a serious threat to any person or the community
- Military Activities/National Security/Aversion of Criminal Activities
- Workers' Compensation
- Correctional institutions, parole or other law enforcement officials
- As required by the Secretary of the Department of Health and Human Services

How to direct us to use and disclose your PHI: Written Authorization.
Other uses and disclosures of your PHI will be made only with your written authorization, unless otherwise permitted or required by law. YOU MAY REVOKE YOUR WRITTEN AUTHORIZATION AT ANY TIME, IN WRITING. If you revoke your written authorization, it will apply to any future actions relating to the release of your PHI. There may be cases where we have already released your PHI prior to receiving your revocation.

Your Patient Privacy Rights.

You have the right to:

- **Inspect and copy your PHI.** You may make a written request to our clinic and pay the copying/mailing fee to look at and receive a copy of your designated record set. The designated record set contains medical and billing records as well as other records we use to make decisions about your health care. We must respond within thirty (30) days (or sixty (60) days if extra time is needed). Under federal and state law, however, you may be denied access to inspect or copy the following records: psychotherapy notes, information compiled in the reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and PHI that is subject to law that prohibits access to PHI. You may have the right to a review upon denial. Please contact the Clinic Privacy Officer if you have any questions about access to your medical record.

- **Request restrictions of your PHI.** You may ask us to limit how we use or disclose any part of your PHI as explained above, except for the typical uses and disclosures described above. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care. You may request a specific restriction by writing the request and to whom the restriction applies on the authorization form. We do not have to agree to your request. In the event we agree, we will state the agreement in writing. We have the sole right to deny a request if unreasonable.

- **Request to choose how we communicate with you.** You have the right to ask that we send information to you in a specific manner. For example: Work address rather than home, or e-mail rather than regular mail. We must agree to your request as long as it would not be disruptive to our operations to do so. We may condition our agreement to honor your request by asking you for specific information as to the alternative address, method of contact and the cost. We will not request an explanation from you as to the basis for the request. You must make this request in writing, addressed to the Clinic Privacy Officer.

- **Request your doctor amend your PHI.** You may make a written request to our clinic for the doctor to consider amending the PHI in your designated medical record set to make it more accurate and complete or correct an error. You must state the reason for the request. We must respond within sixty (60) days (or 90 days, if extra time is needed). We may deny your request for an amendment. If we deny your request, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. You then may have this

reviewed by another provider. If we agree to make the change, we will ask you who to notify of the change. Please contact the Clinic Privacy Officer listed above if you have questions about amending your medical record.

- **Receive a list of disclosures we have made of your PHI.** Beginning April 14, 2003, you may make a written request for a list of all our uses and disclosures of your PHI other than: for treatment, payment, clinic operations; to yourself; or, those with valid authorization. We must respond in sixty (60) days (or 90 days if extra time is needed). The list will be for a 12-month period unless you ask for a shorter time. You are entitled to one (1) free accounting each year. There will be a reasonable charge for any additional accounting requests during the year. The right to receive this information is subject to certain exceptions and restrictions.

- **Receive a copy of this Notice.** You may receive an additional paper or electronic copy of this Notice from us.

If you want to exercise any of these rights and would like assistance, please contact our Clinic Privacy Officer in person or in writing during our normal clinic hours.

Our Responsibilities.
We reserve the right to make changes to this Notice, which will affect the PHI we maintain at that time. Our duty, as your healthcare provider, is to maintain your privacy in accordance with law, abide by the terms of this privacy Notice, accommodate reasonable requests or notify you if we cannot, and provide you with a revised copy of this Notice. You can obtain a copy of any revised Notice by calling our clinic or visiting our clinic and picking up a copy.

- Notices are always available in our clinic for your review.
- This Notice is also published on our website.

Complaints.
If you believe your privacy rights have been violated, you may complain by providing a written statement to our clinic and to the Secretary of Health and Human Services (HHS) at: Office of Civil Rights, US Department of Health and Human Services, 200 Independence Ave., S.W., Room 509F, HHH Building, Washington, D.C. 20201. **We will not retaliate against you for filing a complaint.** We will not require you to waive the right to file a complaint with HHS as a condition to receive treatment from us. You may also contact our Privacy Official if you have questions or comments about our privacy practices.

Effective Date: April 14, 2003
Thank you for allowing us to provide your healthcare and for your confidence in the strict privacy procedures we have established to protect your PHI.

PRIVACY NOTICE ACKNOWLEDGMENT

The signature below acknowledges a copy of this Notice was RECEIVED (not necessarily read).

Date	Patient/Legal Representative Signature
	State Capacity, if Legal Representative

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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Compassion Women's Clinic to use and disclose protected health information (**PHI**) about me to carry out treatment, payment and healthcare operations (**TPO**). Compassion Women's Clinic has a Notice of Privacy Practices that provides a more complete description of such uses and disclosures.

With this consent, Compassion Women's Clinic may call my home, email, or text to my personal accounts or other alternative location as directed and transmit any items that assist the practice in carrying out clinical management, such as;

(1) Appointment reminders with the provider's name, appointment date and time
(2) Insurance items
(3) Any calls pertaining to my clinical care, including normal lab results. (A message will be left to call the office for abnormal lab results)

I prefer to be contacted by: email phone text other _____

I decline to be contacted by: email phone text other _____

Signed: **AGREE**_____ **DISAGREE**_____

Contact Information:_____

I give Compassion Women's Clinic permission to speak to the following individual(s) on my behalf regarding PHI.

_____

_____

As a part of an OB/GYN practice, many of our patients will send us photographs of their newborn and/or children we have delivered. We assume that when we receive these photographs you are giving us permission to display them on our website or in the office. If you do not wish these photographs to be displayed, you are responsible for notifying us, in writing, that you do not wish to have the photograph(s) displayed.

AGREE_____ **DISAGREE**_____

By signing this form, I am consenting to Compassion Women's Clinic permission to proper use and disclosure of my PHI.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Compassion Women's Clinic may decline to provide treatment to me.

_____

Signature of Patient or Legal Guardian Patient's Name

_____

Print Name of Patient or Legal Guardian Date

COMPASSION WOMEN'S CLINIC
FINANCIAL PAYMENT POLICY

REGARDING INSURANCE: We do our very best to understand the financial health of our patients. In doing so, our office participates with Medicare and many managed care insurance companies. Should your insurance coverage be with one or more of these companies, we will bill your insurance company along the guidelines of our contract. However, co-payments, co-insurances, and deductibles that have not been satisfied, are the responsibility of the patient and payment is expected at the time services are rendered. If you have an insurance with which we do not participate, we ask that payment be made at the time services are rendered and your insurance company will reimburse to you any amount due. As a courtesy to our patients, we will submit a claim to your insurance company.

OUR PROMISE: We have all been patients at one time or another. Our clinic staff genuinely desires to use all the experience we have to make sure your time with us is both rewarding and worth your faith in us. To that end, we will promise to you that no procedure will be performed unless we have thoughtfully considered all possible alternatives and included you in that discussion. We promise to work diligently to maintain your financial health in the process, foregoing expensive alternatives if more affordable solutions might be to your advantage.

SPECIAL NEEDS: There are times when making a payment can be a financial hardship. It may be necessary to set up a payment plan for a patient who cannot comply with our financial policy. If you are in need of special payment arrangements, please advise us as soon as possible so that we may work to protect your financial health to the best of our ability. We offer very flexible payment arrangements that will fit your needs.

Informing our patients about our financial policy assists us in providing the best service to our patients. Thank you for taking the time to read this policy statement. Should you have further questions or comments, please ask to speak to Tony Carozza, our clinic manager and patient advocate, or Dr. Carozza.

REMEMBER, OUR GOAL IS TO HELP YOU GET WELL AND STAY WELL, AND WE TAKE THIS VERY SERIOUSLY!

I hereby understand the financial policy of this office. I guarantee payment of all charges incurred for the account of the below patient. In the event I default on my payment, I further agree to pay any outstanding attorney's fees, credit service fees, 5% interest, court costs, and related collection fees incurred to procure that payment.

_____ _____

Patient or Guardian Signature (Must be 18 or older to sign) | Date

_____ _____

Please print patient name | Patient Social Security Number