PHYSICIANS TO WOMEN

1815 S Kanner Hwy, Stuart, FL 34994
1945 SE Port St Lucie Blvd, Port St Lucie, FL 34952
1304 N Lawnwood Cir, Fort Pierce, FL 34950
Phone: (772) 288-2992 Fax: (772) 288-2999

Patient Information

Patient Last Name:_____ First Name:_____ Middle Init: _____

Address:_____ City:_____ State:_____ Zip:_____

Home #:_____(check if okay to leave message)_____ Mobile:_____(check if okay to leave message)_____

Date of Birth:_____ SS#:_____ Marital Status: _____ Race:_____

E-mail:_____

Emergency Contact:_____ Relationship:_____ Phone #: _____

Primary Care Physician:_____ Phone #:_____

Referring Physician:_____ Phone #:_____

Primary Insured Information

Name:_____ DOB:_____ Relationship to patient:_____

Employer:_____ Work Phone#:_____

Employment Status (please check one): _____Employed _____Retired _____COBRA

ALL STUDENTS AND/OR MINORS (UNDER 18) MUST FILL IN THIS SECTION		
Mother's Name	Street Address, City, State, Zip	Home Phone ( )
Mother's Social Security#	Mother's Employer's Address, City, State, Zip	Mother's Employer Phone ( )
Father's Name	Street Address, City, State, Zip	Home Phone ( )
Father's Social Security#	Father's Employer's Address, City, State, Zip	Father's Employer Phone ( )

Insurance and Billing Information

In order to be seen today we must have a copy of your insurance card and driver's license or photo ID. If you do not have your card with you, you may settle your account in full today and our office will provide you with a receipt to file your insurance. You may also choose to reschedule your appointment for another day.

I understand that by signing below I am responsible for payment of any and all fees for services rendered. I authorize payment to Physicians To Women and agree that I am responsible for all unpaid balances. Payment is due when services are rendered. Delinquent balances will be referred to collection according to normal office policy and interest charges may accrue on unpaid balances in the amount of 18% annually.

Authorization for release of medical record

I authorize that all healthcare providers may provide medical care as deemed appropriate to me or the above indicated underaged minor. I authorize Physicians To Women to release requested information to my insurance company for the purpose of billing and collection.

I further authorize Physicians To Women and it's physicians to have complete access to and or a copy of my Inpatient medical records for the purpose of medical treatment and continuity of care from St Lucie Medical Center and/or any other medical facility.

_____ _____ _____

Signature Relationship Date

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HIPAA RELEASE OF INFORMATION AUTHORIZATION

PLEASE LIST BELOW THE AUTHORIZED REPRESENTATIVE(S) THAT WE MAY SPEAK WITH ABOUT YOUR HEALTHCARE. YOU MAY AT ANY TIME, WITH WRITTEN AUTHORIZATION, CHANGE OR REVOKE THIS AUTHORIZATION. BY COMPLETING THIS FORM PLEASE BE AWARE THAT YOU AUTHORIZE THE HEALTH CARE PROVIDERS, AND STAFF OF PHYSICIANS TO WOMEN TO DISCUSS ALL YOUR HEALTHCARE NEEDS, BILLING ISSUES, AND QUESTIONS WITH THOSE LISTED BELOW.

Name	Relationship	Phone Number
Name	Relationship	Phone Number
Name	Relationship	Phone Number
Name	Relationship	Phone Number

Patient Name (Printed) _____ Date of Birth _____

Patient Signature _____

Date _____

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Financial Policy

We are committed to providing you with the best possible medical care; if you have special needs; we are here to work with you. The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services.

Our office participates with a variety of insurance plans. **It is your responsibility to:**

- Bring your insurance card at every visit.
- Be prepared to pay your copay at each visit. Payment can be made by cash, check, or credit card.
- For medical care **not covered** under your insurance, payment in full is due at the time of visit.

If you have insurance that we do not participate in, our office is happy to file claim upon request; however, **payment in full is expected at time of service**.

If you are an obstetrical patient, you will meet with our OB Coordinator on your first visit to set up a financial agreement and again on your 32nd week to re-review your financial history.

Referrals: It is your responsibility to bring any required referrals for treatment, **at or prior to the visit**. If you do not have the referral, your visit may be rescheduled, or you may be financially responsible.

If the patient is a minor (18 years or younger) the parent or guardian must sign below. The parent, guardian or unaccompanied minor is responsible for any payment due at time of service, bringing the necessary referrals and insurance cards.

If you have questions about your insurance, we are happy to help you. Specific coverage issues, however, should be directed to your insurance company member services department (number is on the insurance card).

Our practice firmly believes that a good physician/patient relationship is based upon understanding and good communications. Questions about financial arrangements should be directed to the physician's office.

Please sign that you have read and agree to this Financial Policy.

_____ _____
Signature of Patient or Responsible Party Date

_____ _____
Signature of Co-Responsible Party Date

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Consent Agreement

Consent to the Use and Disclosure of Health Information for Treatment, Payment or Healthcare Operations

I _____, understand that as part of my healthcare this practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment, I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many health professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand if I wish to obtain a copy of *The Notice of Privacy Practices* that provides a more complete description of information uses and disclosures, one will be made available for me. I understand that I have the right to review the notice prior to signing the consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will make a copy available. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I understand and authorize, that at times it may be necessary for Physicians to Women to call my home or place of business and leave messages on an answering machine, voice mail or e-mail. (content of such messages will NOT include personal/medical information)

For purposes of proper medical treatment, Physicians to Women will give personal health information (PHI), including medical history and all test and lab results, of all pregnant patients directly to the birthing hospital, baby's pediatrician, other specialist needed for the mother's and the baby's care. The hospital, the pediatrician and any other needed specialist may make the patient's PHI part of their medical record for the patient and or baby. Transfer of this information will help hospital staff; the pediatrician and any other needed specialist appropriately care for and treat a patient and or newborn baby.

I have been presented with a copy of the notice of privacy practices detailing how my health information may be used and disclosed as permitted under Federal and State Law and outlining my rights regarding my health information. ____(Please initial)

I wish to have the following restrictions to the use or disclosure of my health information; _____

_____

I fully understand and accept/decline the terms of this consent.

Signature: _____ Date: _____

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REVIEW OF SYMPTOMS

Date:_____ Name: _____ DOB:_____

PLEASE CIRCLE ANY OF THE FOLLOWING YOU MAY BE EXPERIENCING

GENERAL:	Fevers Chills Weight Gain Weight Loss Changes in Appetite
EYES:	Change in Vision Pain Double Vision Eye Infection
EARS, NOSE, THROAT:	Hearing Loss Mouth Ulcers Seasonal Allergies Nasal Congestion
CARDIOVASCULAR:	Palpitations Difficulty Breathing Chest Pain Shortness of Breath with Exercise
RESPIRATORY:	Chronic Cough Wheezing Coughing Blood Shortness of Breath Snoring
GASTROINTESTINAL:	Heartburn Nausea Vomiting Pain Swelling Constipation Diarrhea Blood in Stool Hemorrhoids Fecal incontinence
GYNECOLOGICAL:	Heavy Bleeding Irregular Bleeding Painful Intercourse Painful Periods Vaginal Itching Vaginal Discharge
MENOPAUSE:	Decreased Libido Night Sweats Hot Flashes Bleeding after Menopause
GENITOURINARY:	Burning/Pain with Urination Blood in Urine Urinary Frequency Leaking Urine Retaining Urine
BREAST:	Lumps Pain Redness Nipple Discharge
MUSCULOSCKELETAL:	Bone Pain Joint Pain Joint Swelling Muscle Aches History of Bone Fracture
SKIN:	Rashes Changing Moles Dry Skin Fine lines or wrinkles around eyes, mouth and/or forehead
NEUROLOGICAL:	Paralysis Arm/Leg Weakness Loss of Speech Memory Loss Vision Loss Vertigo Headaches Dizziness
PSYCHIATRIC:	Anxiety Sadness Moodiness Irritability
ADDITONAL CONCERNS:	

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NEW PATIENT QUESTIONNAIRE

Date:_____ Name: _____ DOB:_____

What is the reason for today's visit? _____Annual/Wellness _____Problem (please give brief description of problem)

_____

_____

Are you currently having any urinary symptoms? ___Yes ___No If yes, please specify: _____

_____

What is the name and location of the pharmacy you would like listed in your chart?_____

_____

What MEDICATIONS (with dosages) are you currently taking? _____

_____

_____

Please list any DRUG ALLERGIES and the reaction you have had to them:_____

_____

_____

YOUR GYNECOLOGICAL History:

When was the first day of your last period? _____

When was your last mammogram? _____

When was your last bone density? _____

When was your last pap smear? _____ Any history of an abnormal pap smear? _____

Any history of cervical dysplasia? _____

Are you currently sexually active? __Yes __ No If you have had sex, did you begin before the age of 18?_____

Have you had greater than 5 partners in your lifetime? __Yes __No

Do you have any history of the following STDs?

_____Gonorrhea _____Chlamydia _____Genital warts _____Syphilis _____Herpes _____HIV _____HPV

What are you CURRENTLY using for Birth Control? _____

How old were you when you had your first period: _____ Are you in menopause?_____ If yes, at what age?____

Do you have a history of Endometriosis? __Yes __No

Do you have a history of Uterine fibroids? __Yes __No

Do you have a history of Infertility? __Yes __No

Do you have a history of Recurrent Ovarian Cysts? Yes No

How long do your periods last? _____ Is the time between periods 0-4 days 5-7 days 8+ days, regular or irregular?

Do you have excessive cramping? YES NO Is your menstrual flow, light to moderate or excessive?

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YOUR OBSTECTRICAL History:

Number of total pregnancies:_____ Number of ectopic pregnancies:_____

Number of full-term deliveries:_____ Number of stillbirths:_____

Number of premature deliveries:_____ Number of living children:_____

Number of elective abortions:_____ Number of miscarriages:_____

Number of c-sections:_____ Reason for c-sections?_____

Any complications of pregnancies? _____

Any problems getting pregnant? _____

Could you be pregnant now? _____

Do you have any FAMILY HISTORY of any of the following? (Please circle your answer) *if yes, please give details.

Heart Disease	YES	NO	Relative_____
High Blood Pressure	YES	NO	Relative_____
Stroke	YES	NO	Relative_____
Diabetes	YES	NO	Relative_____
Alcoholism	YES	NO	Relative_____
Depression/ Anxiety	YES	NO	Relative_____
Cancer	YES	NO	Relative_____
Cervical Cancer	YES	NO	Relative_____
Colon Cancer	YES	NO	Relative_____
Breast Cancer	YES	NO	Relative_____
Lung Cancer	YES	NO	Relative_____
Ovarian Cancer	YES	NO	Relative_____
Uterine Cancer	YES	NO	Relative_____
Kidney Disease	YES	NO	Relative_____
Osteoporosis	YES	NO	Relative_____
Thyroid Disease	YES	NO	Relative_____
Seizures/Epilepsy	YES	NO	Relative_____
Respiratory Disease	YES	NO	Relative_____
Migraine Headaches	YES	NO	Relative_____
Blood Clots	YES	NO	Relative_____
Hepatitis	YES	NO	Relative_____
Autoimmune Disorder	YES	NO	Relative_____

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YOUR RISK FACTORS: (Please circle your answer)

Do you CURRENTLY smoke cigarettes?	Yes	No	If yes, year started _____
How many cigarettes do you smoke per day?	_____		
Are you a FORMER smoker?	Yes	No	If yes, year quit _____
Are you exposed to secondhand smoke?	Yes	No	
Do you currently use drugs?	Yes	No	If yes, what type?_____
Do you drink caffeine?	Yes	No	__coffee __tea __soda __other
How many drinks containing caffeine do you have per day?	_____		
Do you drink alcohol?	Yes	No	If yes, what type?_____
How many drinks containing alcohol do you have per day?	_____		
Do you exercise?	Yes	No	If yes, how often?_____
Do you use your seatbelt 100% of the time?	Yes	No	
Are you exposed to the sun frequently?	Yes	No	If yes, how often? _____

Have YOU had any Surgeries? *if yes, please give type and date._____

_____

_____

Do you have any PERSONAL HISTORY of any of the following? (Please circle your answer) *if yes, please give details.

Cancer	YES	NO	Details_____
Breast Cancer	YES	NO	Details_____
Colon Cancer	YES	NO	Details_____
Uterine Cancer	YES	NO	Details_____
Lung Cancer	YES	NO	Details_____
Ovarian Cancer	YES	NO	Details_____
Other Cancers	YES	NO	Details_____
Heart Disease	YES	NO	Details_____
High Blood Pressure	YES	NO	Details_____
Diabetes	YES	NO	Details_____
Osteopenia	YES	NO	Details_____
Osteoporosis	YES	NO	Details_____
Thyroid Disease	YES	NO	Details_____
Migraine/Headaches	YES	NO	Details_____
Seizures/Epilepsy	YES	NO	Details_____
Stroke	YES	NO	Details_____
Depression/ Anxiety	YES	NO	Details_____
PMS	YES	NO	Details_____
COPD	YES	NO	Details_____
Autoimmune Disorder	YES	NO	Details_____
Bladder infections	YES	NO	Details_____
Blood Clots	YES	NO	Details_____
Hepatitis	YES	NO	Details_____
Kidney Disease	YES	NO	Details_____
Blood Transfusions	YES	NO	Details_____

THANK YOU FOR CHOOSING PHYSICIANS TO WOMEN
FOR YOU HEALTHCARE NEEDS

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Consent for Pelvic Examination

According to The American College of Obstetricians and Gynecologists, the pelvic examination is part of the evaluation of women presenting with many common conditions, including pelvic pain, abnormal bleeding, vaginal discharge, and sexual problems. Pelvic exams—both in the office and while under anesthesia— are also an important part of evaluation for gynecologic procedures to ensure safe completion of the planned procedure. Often, a pelvic examination is performed for women without symptoms while looking for gynecologic cancer, infection, and pelvic inflammatory disease.

- A pelvic examination is an assessment of the external genitalia; internal speculum examination of the vagina and cervix; bimanual palpation of the adnexa, uterus, and bladder; and sometimes rectovaginal examination.

- Reasons for a pelvic exam can include (but are not limited to) health screening, abnormal bleeding, pelvic pain, sexual problems, vaginal bulge, urinary issues, or inability to insert a tampon. Other indications include patients undergoing a pelvic procedure (e.g., endometrial biopsy or intrauterine device placement). Also, pelvic examination is indicated in women with current or a history of abnormal pap results, gynecologic cancers, or toxic exposures.

- The potential benefits of a pelvic examination include the detection of vulvar, vaginal, cervical, uterine, and ovarian cancers and precancers, yeast and bacterial vaginosis, trichomoniasis, and genital herpes, early detection of treatable gynecologic conditions before symptoms begin occurring (e.g. vulvar or vaginal cancer), as well as incidental findings such as dermatologic changes and foreign bodies. Additionally, screening pelvic examinations in the context of a well woman visit may allow gynecologists to explain a patient's anatomy, reassure her of normalcy, and answer your specific questions.

- The potential risks of a pelvic exam may include (but are not limited to) fear, anxiety, embarrassment (reports ranged from 10% to 80% of women) or pain and discomfort (from 11% to 60%).

- There are few alternatives to pelvic examination, the alternatives are not as effective for providing diagnostic or evaluative information and carry their own set of potential risks. If you have concerns, you should discuss with your healthcare provider.

I _____ understand that this Patient Consent Form is required by law. I understand that I need to sign this form to show that I am making an informed decision to have pelvic examinations and I have read and understand the above.

The provider or their delegate has explained to me the nature, purpose, and possible consequences of each procedure as well as risks involved, possible complications, and possible alternative methods of treatment. I also know that the information given to me does not list every possible risk and that other, less likely problems could occur. I was not given any guarantee from anyone about the final results of this procedure.

_____ ____/____/_____
Signature Date

I understand that my provider is involved in educating tomorrow's medical professionals and that familiarizing students with the female anatomy and instilling a physician workforce with confidence in pelvic examination skills is essential. I consent to pelvic examination by the medical professional student under the supervision of my medical provider.

_____ ____/____/_____
Signature Date