Perfectly Female Women's Health Care, P.C.

Patient Information Sheet

Name (Last): _____(First):_____(MI):_____

Soc Sec #:_____ Marital Status: Single Married Divorced (please circle one) Widowed Separated

Home (_____)-_____.

Date of Birth: _____ Age: _____

Work (_____)-_____.

Address: _____

Cell (_____)-_____.

City: _____State: _____Zip:_____

Email _____

****

Guarantors Name: _____
(person the insurance is carried by)

Relationship to Guarantor: Self Spouse Child Other
(please circle one)

Insurance Company: _____

Guarantor Info (if Guarantor is not = SELF)

Social Security #: ……..……

Employer:……..……..……

Date of Birth: ……..……..……..…

****

Emergency Contact: _____ **Phone (_____)-_____.**

Person(s) we may discuss your Medical Information with:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

****

Employer: _____ Occupation: _____

Primary Care MD: _____ Phone (_____)-_____.

Referred By: _____

ALL OF THE ABOVE ARE REQUIRED FIELDS

This office will file your insurance claims; however, the patient is responsible for all fees, regardless of insurance coverage. If you are a self pay patient, you will be responsible for the office visit today and the lab will bill you for any labs that are done**. If your co pay is not paid when services are rendered, an additional charge of $10.00 will be added to your statement to cover our cost of sending a bill.** **This office orders lab tests according to medical necessity.** Your insurance company will determine what is paid for. All lab work will be billed to your insurance company by the laboratory**. If there are any questions regarding bills received from a lab, please contact the lab directly. I understand that I am financially responsible for all charges for services to me, including any balance remaining after possible insurance payments.** I authorize payment of medical benefits to Perfectly Female Women's Health Care, P.C. for services provided. I authorize the release of medical information needed to process any insurance claim. I acknowledge the Virginia Code: Section 32.1-45.1, which states that should an exposure of my blood occur to a healthcare worker, I may be tested for Hepatitis B and C, and HIV. I acknowledge that Perfectly Female Women's Health Care utilizes the Prescription Monitoring Program for the health and well-being of our patients.

SIGNED_____DATE_____

Patient History

Date: ___/___/_____

Patient Name: _____ Date of Birth: ___/___/_____

Marital Status: Sing/Mar/Wid/Div/Sep Referred By: _____

Reason for Visit: _____

DRUG Allergies: _____

Past Medical/Family History: Check if You(**Pers**) or any Blood Relative(**Fam**) had any of these conditions:

	Pers	Fam		Pers	Fam
Weight Loss/Gain	☐	N/A	Kidney Disease/ Chronic Urinary Infections	☐	N/A
Chronic Headaches/Migraine	☐	N/A	Arthritis/Joint Pain	☐	☐
Heart Disease	☐	☐	Blood Transfusions	☐	N/A
High Blood Pressure	☐	☐	Anemia/Blood Disorder	☐	N/A
High Cholesterol	☐	☐	Skin Disorder (Other)	☐	☐
Respiratory (Lung) Disease/Asthma	☐	☐	Diabetes	☐	☐
Thyroid Disease	☐	☐	GastroIntestinal (GI) Disorder	☐	☐
Jaundice/Hepatitis	☐	☐	Epilepsy/Seizures	☐	☐
AutoImmune Disease (Lupus)	☐	☐	Sleep Apnea	☐	N/A
Anxiety/Depression	☐	☐	Cancer (Type) --->	☐	☐
Sexually Transmitted Diseases (STD)			Breast Cancer	☐	☐
☐ Chlamydia ☐ HPV (Human Papilloma Virus)			Ovarian Cancer	☐	☐
☐ Gonorrhea ☐ HSV (Herpes Simplex Virus)			Colon Cancer	☐	☐

Hospital Admissions: List Operations & Serious Illnesses (including Plastic Surgery)

Year	Reason for Admission	Year	Reason for Admission

Medications: List all Medications you are Currently Taking (including Over the Counter Drugs)

Dosage	Freq	Medication	Dosage	Freq	Medication

Obstetrical History: Complications ? _____

Total ---> Pregnancies		Premature Babies --->		Miscarriages / Abortions --->		Ectopic ---> Pregnancies		Living ---> Children		Vaginal ---> Deliveries		C-Sections --->	

Menstrual History:

If Menstruating – Date of Last Period (1st day)? _____

Number of days that you bleed ? _____ days

Periods are :

☐ Regular - every _____ Days

☐ Irregular - every _____ Days / Weeks / Months

With your Periods – Do you have :

☐ Pain ☐ Irritability ☐ Bloating

☐ Cramps ☐ Depression ☐ _____

Birth Control – Current Method:

☐ Pill	☐ IUD	☐ Depo Provera	☐ Withdrawal	☐ Vasectomy
☐ Patch	☐ Condom	☐ Implanon	☐ Rhythm	☐ Tubal
☐ Ring				☐ Essure

Sexual History:

Have you ever been Sexually Active ? Y / N

Are you Sexually Active ? Y / N

If yes, how often _____ times / Month

Wish to Discuss ? Y / N

Is Intercourse Satisfactorily ? Y / N

Pain / Bleeding with Intercourse ? Y / N

Pelvic Exam:

Date of Last Exam	Date of Last Pap	☐ Normal ☐ Abnormal	Have you ever had an Abnormal Pap ? Y / N Explain _____

Social History:

SMOKING	Cigs/ Day		Num Yrs		ALCOHOL	Number of Drinks/Wk		COFFEE /TEA	Cups /Day		STREET DRUGS	

Perfectly Female Women's Health Care, P.C.

1860 Town Center Drive, Suite 110
Reston, Virginia 20190
703-796-0200 FAX: 703-796-1685

20925 Professional Plaza, Suite 200
Ashburn, Virginia 20147
703-726-9000 FAX: 703-726-9105

Consent Agreement

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) does not require that health care providers obtain a consent agreement as it relates to the use and disclosure of individually identifiable health information (IIHI), but many practices will continue to use the Consent Agreement for other purposes.

Though not necessary to have your consent to allow us to use or disclose your IIHI to others who will treat you or support in providing you quality health care services, it is important to have your consent to use or disclose your IIHI to health care plans to insure accurate and timely payments for the services rendered. The law requires that we inform you of our policy regarding the protection of your IIHI through our Privacy Notice. We may already have a consent agreement from you. Please refer to our Privacy Notice for a full explanation of how this office will protect your individually identifiable health information (IIHI).

Thank you for your continued confidence in our practice and for supporting our new requirements.

The following is a statement that allows us the necessary latitude to work within the new requirements.

I, _____, have been presented with a Privacy Notice explaining my rights regarding my individually identifiable health information (IIHI). I consent to the use and/or disclosure of my IIHI for purposes of treatment, payment or other health care operations (TPO). Other uses of my IIHI will require an authorization from me for the specific intention of disclosure.

Patient: _____ Date: _____

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Notice of Privacy Practices

The Department of Health and Human Services, Office of Civil Rights, under the Public Law 104-191, (The **Health Insurance Portability and Accountability Act of 1996) (HIPAA),** mandates that we issue this new revised **Privacy Notice** to our patients. This notice to our patients meets all current requirements as it relates to **Standards for Privacy of Individually Identifiable Health Information IIHI);** affecting our patients. You are urged to read this notice.

Our Privacy Notice informs you of our use and disclosure of your **Protected Health Information (PHI)**, defined as: "any information, whether oral or recorded in any medium, that is either created or received by a health care provider, health plan, public health authority, employer, life insurance company, school or university or clearinghouse and that relates to the past, present or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past present or future payment for the provision of health care to an individual".

Our office will use or disclose your PHI for purposes of treatment, payment and other healthcare purposes as required to provide you the best quality healthcare services that we offer to the extent permitted by your Consent Agreement or in such specific situations, by your signed and dated Authorization. It is our policy to control access to your PHI; and even in cases where access is permitted, we exercise a "minimum necessary information" restriction to that access. We define the minimum necessary information as the minimum necessary to accomplish the intent of the request.

An Authorization differs from a Consent Agreement in that it is very specific with regard to the information allowed to be disclosed or used, the individual or entity to which the information may be disclosed to, the intent for which it may be disclosed, and the date that it was initiated which may include the duration of the authorization. This is a form, separate from the Consent Agreement, and usually used only for one specific request for information. In the event of a non-healthcare related request for personal health information this office will request you to complete an Authorization Form.

You, as our patient, may revoke any Consent Agreement or Authorization at any time and all use and disclosure and administration of related healthcare services will be revised accordingly, with the exception of matters already in process as a result of prior use of your PHI. To revoke either the Consent Agreement or the Authorization you will have to provide this office with a written request with your signature and date and your specific instructions regarding an existing Authorization or Consent Agreement. Any revocation will not apply to information already used or disclosed.

If you had a "personal representative" initiate as Authorization you may revoke that authorization at any time.

You, the patient have access to your health care information and may request to examine your information, may request copies of your information, and under the law you may request amendments to your information. The physician or principal will exercise professional judgment with regard to requests for amendments and is not bound by law to make any changes to the information. If the physician or professional agrees with the request to amend the information, we are bound by law to abide by the changes. **There will be an administrative charge for the copying of these records.**

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In limited circumstances, The Privacy Standard permits, but does not require, covered entities to continue certain existing disclosures of health information without individual authorization for specific public responsibilities.

These permitted disclosures include: emergency circumstances; identification of the body of a deceased person, or to assist in determining the cause of death; public health needs; research, generally limited to when a waiver of authorization is independently approved by a privacy board or Institutional Review Board; oversight of the health care system; judicial and administrative proceedings; limited law enforcement activities; and activities related to national defense and security. There are specific state laws that required the disclosure of health care information related to Hepatitis C, and AIDS. Where the state laws are more stringent than HIPAA Privacy Standard, the state laws will prevail.

We may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when your doctor is ready to see you. We may use or disclose your protected health information, as necessary, to contact you by telephone or mail to remind you of your appointment.

All of these disclosures could occur previously under former laws and regulations however; The Privacy Standard establishes new safeguards and limits. If there is no other law requiring that your information be disclosed, we will use our professional judgments to decide whether to disclose any information, reflecting our own policies and ethical principals.

On some occasions we may furnish your PHI to a third party. This could be an insurance company for the purpose of payment or another health care provider for further treatment or additional services. Although we will institute a "chain of trust" contract and monitor our business associates' contracts with us, we cannot absolutely guarantee that they will not use or disclose your PHI in such a way as to violate the Privacy Standard.

Although the law requires a signed and dated Privacy Notice, this office does not demand that you sign this agreement as a condition of receiving care. It is the law that your rights are communicated in this manner.

It is our practice to retain information about non-healthcare related requests for your health care information for a period of six years.

In complying with the Privacy Standard, we have appointed a Privacy Officer, trained our Privacy Officer and the staff in the law, and implemented policies to protect your PHI. We have instituted privacy and security processes to guard and protect your IIHI. This office is taking and continues to monitor and improve steps for the protection of your information and to remain in compliance with the law.

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Notice of Privacy Practices

ACKNOWLEDGMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

My signature below indicates that I have received a copy of the Privacy Notice of Perfectly Female Women's Health Care, P.C..

Thank you.

_____ Date: _____
Signature of Patient or Personal Representative

_____
Name printed

_____
Signature of Perfectly Female Representative