

UPDATE HEALTH HISTORY

CONFIDENTIAL

Name: _____ Age: _____ Birth Date _____

What is the reason for your visit? **

***We do not do any type weight loss under a medical office visit, if you need to discuss a weight concern please notify the front desk to give you weight loss paperwork.*

PLEASE INFORM OFFICE STAFF OF ANY INSURANCE, ADDRESS, JOB OR PHONE CHANGES:

SYMPTOMS Check systems you currently have or have had in the past year

<p style="text-align: center;">GENERAL</p> <p><input type="checkbox"/> Major weight gain <input type="checkbox"/> Major weight loss <input type="checkbox"/> Fatigue <input type="checkbox"/> Changes in sleep pattern <input type="checkbox"/> Changes in appetite <input type="checkbox"/> Fever</p> <p style="text-align: center;">EYE, EAR, NOSE, THROAT</p> <p><input type="checkbox"/> Visual changes <input type="checkbox"/> Double vision <input type="checkbox"/> Ringing in the ears <input type="checkbox"/> Hearing loss <input type="checkbox"/> Ear pain <input type="checkbox"/> Sinus congestion or pain <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Hoarseness <input type="checkbox"/> Difficulty swallowing</p> <p style="text-align: center;">DERMATOLOGICAL</p> <p><input type="checkbox"/> Rash <input type="checkbox"/> Non-healing sores <input type="checkbox"/> Changes in moles <input type="checkbox"/> Warts</p> <p style="text-align: center;">BREASTS</p> <p><input type="checkbox"/> Pain <input type="checkbox"/> Lumps <input type="checkbox"/> Discharge</p> <p style="text-align: center;">RESPIRATORY</p> <p><input type="checkbox"/> Wheezing <input type="checkbox"/> Coughing <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Recent upper respiratory infection</p>	<p style="text-align: center;">CARDIOVASCULAR</p> <p><input type="checkbox"/> Chest pain <input type="checkbox"/> Palpitations <input type="checkbox"/> Murmur <input type="checkbox"/> Rapid Heartbeat</p> <p style="text-align: center;">GASTROINTESTINAL</p> <p><input type="checkbox"/> Pain <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Rectal bleeding</p> <p style="text-align: center;">MUSCLE/JOINT/BONE</p> <p><input type="checkbox"/> Muscle pain <input type="checkbox"/> Joint pain <input type="checkbox"/> Decreased range of motion <input type="checkbox"/> Weakness</p> <p style="text-align: center;">NEUROLOGICAL</p> <p><input type="checkbox"/> Frequent headaches <input type="checkbox"/> dizzy <input type="checkbox"/> Loss of consciousness <input type="checkbox"/> Seizures <input type="checkbox"/> Numbness</p> <p style="text-align: center;">ENDOCRINE</p> <p><input type="checkbox"/> Intolerance to heat <input type="checkbox"/> Intolerance to cold <input type="checkbox"/> Excessive hunger <input type="checkbox"/> Excessive thirst</p> <p style="text-align: center;">PSYCHIATRIC</p> <p><input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Moody <input type="checkbox"/> Irritable <input type="checkbox"/> Suicidal thoughts</p>	<p style="text-align: center;">QUESTIONS</p> <p>Hysterectomy ___ Yes ___ No</p> <p>If yes, do you still have your ovaries? ___ Yes ___ No</p> <p>Date of last menstrual period _____</p> <p>How often does your cycle occur? _____</p> <p>Duration of cycle. _____</p> <p>Is Your Cycle: ___ Heavy ___ Normal ___ Light ___ Painful</p> <p>What type of contraception are you using? _____</p> <p>Date of last Pap Smear _____</p> <p>Result of last Pap Smear Normal ___ Abnormal ___</p> <p>Date of last mammogram? _____</p> <p>Result of last Mammogram Normal ___ Abnormal ___</p> <p>What facility do you want to use for Mammograms? _____</p> <p>Colonoscopy ___ Yes ___ No Date _____</p>	<p style="text-align: center;">QUESTIONS</p> <p>Bone Density ___ Yes ___ No Date _____</p> <p>Result of Bone Density Normal ___ Abnormal ___</p> <p>Are you pregnant? ___ Yes ___ No</p> <p>Are you planning to become pregnant? ___ Yes ___ No</p> <p>Number of Pregnancies _____</p> <p>Number of Living Children _____</p> <p>Number of Miscarriages _____</p> <p>Do you Smoke? _____ ___ Per Day ___ Per Week ___ Per Month</p> <p>Do you drink Alcohol? _____ ___ Per Day ___ Per Week ___ Per Month</p> <p>Do you Exercise? _____ ___ Per Day ___ Per Week ___ Per Month</p> <p>Do you drink Caffeine? _____ ___ Per Day ___ Per Week ___ Per Month</p> <p>Primary care physician _____</p>
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Women's Wellness & Aesthetics

FINANCIAL POLICY

OUR OFFICE IS A PAYMENT AT TIME OF SERVICE PRACTICE.

We accept Cash, Checks, MasterCard and Visa

We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policies.

Payment for services **not covered by your insurance plan** is due at the time of service. Payment for services **denied by your insurance plan** is due immediately upon receipt of a statement from our office. We accept checks, cash, money, orders, debit cards, MasterCard and Visa. We will be happy to file your insurance if we are listed as a "Participating Provider" on your plan. You must realize, however, that:

- Your insurance is a contract between you, the employer and the insurance company. We are not a party to that contract and are not responsible for knowing all the specific benefits of your individual plan. It is your responsibility to know your benefits and inform this office if there are any diagnoses that are not covered by your plan. Most plans will not disclose reimbursement until they receive all information from your visit, so please be aware you may owe more than collected on the day of service.
- If any lab testing is done in the office, you may receive a bill from an outside lab and/or pathologist. We use Clinical Pathology Labs (CPL). It is your responsibility to inform this office that your insurance policy requires you to use a different lab other than CPL. It is your responsibility to know your benefits and inform this office if there are any diagnosis that are not covered by your plan.
- We will file your insurance on plans we participate with only if we have a current copy of your insurance card and all the pertinent information required for filing claims (insured's social security number, date of birth, etc.).
- Not all services are covered benefits under your insurance contract. Some insurance companies arbitrarily select certain services they will not cover or they may set maximum limitations. Any services identified as such are your responsibility and payment will be due at time of service, or within 30 days of a receipt of statement from us.
- If your plan requires a referral from a PCP (Primary Care Physician) before seeing us, it is your responsibility to obtain that authorization prior to being seen in our office.
- **\$30.00 Fee for all cancellations less than 24 hours notice.**

We must emphasize that the filing of claims is a courtesy that we extend to our patients. All charges are your responsibility from the date the service is rendered. It is understood that temporary financial problems may affect timely payment of your account. If such problems arise, please contact us immediately for assistance in the management of your account. If you have any questions regarding the above information, please do not hesitate to ask.

By signing below you agree that you have read the above information.

Patient (Guardian) Signature

(Printed Name)

(Date)



Women's Wellness & Aesthetics

FINANCIAL AGREEMENT

OUR OFFICE IS A PAYMENT AT TIME OF SERVICE PRACTICE.

We accept Cash, Checks, MasterCard, Visa, Debit, or Care Credit

According to the HIPAA title II law passed we are required to collect your copay and co-insurance. If for any reason you have a balance after your insurance pays, it must be paid within 30 days from the date of the statement. We reserve the right to offer a reduced fee or charity care based on ability to pay.

I hereby authorize, Womens Wellness & Aesthetics, to furnish my insurance company, its representatives or any other insurance company or attorney, the customary medical information requested about me. I understand that Womens Wellness & Aesthetics will file my insurance on my behalf and that I will be responsible for following up with my insurance company for timely payment of services rendered. I agree to pay in full for all balances due that are not paid for by the insurance company.

FINANCIAL AGREEMENT

I have read the above and agree to abide by its contents.

Signature of Patient, Parent, Guardian

PRINTED name of Patient, Parent, Guardian

Date _____

Relationship to Patient _____

Signature of Witness

PRINTED name of Witness

Date _____

INSURANCE ASSIGNMENT AND RELEASE

I hereby assign Title II and all interest in and reimbursement benefits from my insurance company, _____ money to *Laura Anderson, RNC, WHNP, and Womens Wellness & Aesthetics Robert McLeroy, M.D.* I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. I hereby authorize, Womens Wellness & Aesthetics, to furnish my insurance company, its representatives or any other insurance company or attorney, the customary medical information requested about me. I understand that Womens Wellness & Aesthetics will file my insurance on my behalf and that I will be responsible for following up with my insurance company for timely payment of services rendered. I agree to pay in full for all balances due that are not paid for by the insurance

Signature of Patient, Parent, Guardian

PRINTED name of Patient, Parent, Guardian

Date _____

Relationship to Patient _____

Signature of Witness

PRINTED name of Witness

Date _____



Women's Wellness & Aesthetics

Laura Anderson, RNC, WHNP

1213 North Grand Ave.

Gainesville, Texas 76240

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE DISCLOSED AND HOW YOU MAY ACCESS THIS INFORMATION.

HIPAA is the acronym for the Health Insurance Portability and Accountability Act of 1996. HIPAA is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by this office, whether electronically, written, or orally be kept confidential. HIPAA assures that individuals' health information needed to provide and promote high quality health care and to protect the public's health and well being.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operation (TPO), and for other purposes that are permitted by law. It also describes your rights to access and control your protected health information.

What is "Protected Health Information"?

Protected Health Information (PHI) is any "individually identifiable health information" held or transmitted by a Covered entity, in any form, whether electronic, written or oral.

Uses/Disclosures:

We may use and disclose your medical records for treatment, payment, and health care operations.

- **Treatment** refers to providing, coordinating, or managing health care and related services by one or more health care providers, such as annual examinations. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to another physician to whom you have been referred to for further treatment.
- **Payment** refers to such activities as obtaining reimbursement for services, confirming coverage, billing, collections, and utilization review. A prime example would be sending a claim to your insurance company for your visit for payment.
- **Health Care Operations** include any of the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing, functions, cost-management analysis, and customer service.
- **Appointment Reminders** Our practice may use and disclose your public health information to contact you and remind you of an appointment.
- **Test Results** Our practice may disclose your test results via mail or phone call to your designated phone number.

We may use or disclose your protected health information in the following situations without your authorization: Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors, and Organ Donation, Research, Criminal Activity, Military Activity and National Security, Workers' Compensation, and Inmates. Required Uses and Disclosures, under law, would include disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

We may also create and distribute health information by removing all references to individually identifiable information.

We may contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Your Rights:

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restriction on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to requested restriction. If we do not agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures.
- The right to obtain a paper copy of this notice from us upon request.

This notice is effective, as of October 16, 2006, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

Complaints:

You do have recourse in the event that you feel your privacy protections have been violated. You have the right to file a written complaint with our office, or with the our office, or with the Department of Health and Human Service, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office.

For more information about HIPAA or to file a complaint:

The U. S. Department of health and Human Services
Office of Civil Rights
200 Independence Ave, S.W.
Washington, D. C. 20201
(202) 619-0257 or Toll Free (877) 696-6775

We are required, by law, to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA compliance Officer in person or by phone.

Signature below is only an acknowledgement that you understand and have received this Notice of our Privacy Practices:

Print Name: _____

Signature: _____ **Date:** _____



Women's Wellness & Aesthetics

Laura Anderson, RNC, WHNP

1213 North Grand Ave.

Gainesville, Texas 76240

I _____, authorize Women's Wellness and Aesthetics to disclose my information to the following people (i.e.: Spouse, Mother, Sister etc.)

(PLEASE PRINT CLEARLY)

NAME: _____

RELATIONSHIP: _____

NAME: _____

RELATIONSHIP: _____

NAME: _____

RELATIONSHIP: _____

NAME: _____

RELATIONSHIP: _____

Signature: _____ Date: _____