# 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

**GENERAL**
- ☐ Major weight gain
- ☐ Major weight loss
- ☐ Fatigue
- ☐ Changes in sleep pattern
- ☐ Changes in appetite
- ☐ Fever

**EYE, EAR, NOSE, THROAT**
- ☐ Visual changes
- ☐ Double vision
- ☐ Ringing in the ears
- ☐ Hearing loss
- ☐ Ear pain
- ☐ Sinus congestion or pain
- ☐ Nosebleeds
- ☐ Hoarseness
- ☐ Difficulty swallowing

**DERMATOLOGICAL**
- ☐ Rash
- ☐ Non-healing sores
- ☐ Changes in moles
- ☐ Warts

**BREASTS**
- ☐ Pain
- ☐ Lumps
- ☐ Discharge

**RESPIRATORY**
- ☐ Wheezing
- ☐ Coughing
- ☐ Shortness of breath
- ☐ Recent upper respiratory infection

**CARDIOVASCULAR**
- ☐ Chest pain
- ☐ Palpitations
- ☐ Murmur
- ☐ Rapid Heartbeat

**GASTROINTESTINAL**
- ☐ Pain
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Rectal bleeding

**MUSCLE/JOINT/BONE**
- ☐ Muscle pain
- ☐ Joint pain
- ☐ Decreased range of motion
- ☐ Weakness

**NEUROLOGICAL**
- ☐ Frequent headaches
- ☐ dizzy
- ☐ Loss of conciseness
- ☐ Seizures
- ☐ Numbness

**ENDOCRINE**
- ☐ Intolerance to heat
- ☐ Intolerance to cold
- ☐ Excessive hunger
- ☐ Excessive thirst

**PSYCHIATRIC**
- ☐ Anxiety
- ☐ Depression
- ☐ Moody
- ☐ Irritable
- ☐ Suicidal thoughts

**QUESTIONS**

Hysterectomy ___Yes ___No

If yes, do you still have your ovaries? _____Yes _____No

Date of last menstrual period _____

How often does your cycle occur? _____

Duration of cycle._____

Is Your Cycle:
____Heavy _____Normal
____Light _____ Painful

What type of contraception are you using?
_____

Date of last Pap Smear
_____

Result of last Pap Smear
Normal____ Abnormal_____

Date of last mammogram?
_____

Result of last Mammogram
Normal____ Abnormal_____

What facility do you want to use for Mammograms?
_____

Colonoscopy ___Yes ___No
Date_____

**QUESTIONS**

Bone Density ___Yes ___No
Date_____

Result of Bone Density
Normal____ Abnormal_____

Are you pregnant?
____ Yes ____No

Are you planning to become pregnant?
_____ Yes ____No

Number of Pregnancies
_____

Number of Living Children
_____

Number of Miscarriages
_____

Do you Smoke? _____
_____ Per Day
_____ Per Week
_____ Per Month

Do you drink Alcohol? _____
_____ Per Day
_____ Per Week
_____ Per Month

Do you Exercise? _____
_____ Per Day
_____ Per Week
_____ Per Month

Do you drink Caffeine?____
_____ Per Day
_____ Per Week
_____ Per Month

Primary care physician
_____

# HEALTH HISTORY

**CONFIDENTIAL**

Name: _____ Birth Date_____

**Bloodwork done in the past 3 months? ____ Yes ____ No Date_____**
**Physicians' office_____**

**MEDICATIONS:** List **all** medications you take (***Including over the counter medications, herbs, hormones and medications taken as needed)***)

| Medication | Strength | How often | Reason | Prescribing Physician |
|---|---|---|---|---|
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**ALLERGIES:** List all allergies (**medications or substances**)

| Allergy | Reaction |
|---|---|
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**SURGERIES SINCE LAST APPOINTMENT:**

| Surgery | Date | Reason | Hospital |
|---|---|---|---|
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**This office charges a $30.00 appointment cancellation fee if not notified 24 hours in advance**

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 INFORMTION.

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 heath 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: _____