
| PATIENT INFORMATION | | | |
|---|---|---|---|
| Patient Name: | | | Date of Birth: |
| Address: | | | |
| City: | | ST: | Zip Code: |
| Marital Status: | Home Phone: | | Cell Phone: |
| Email Address: | Emergency Contact Name: | | Phone: |

| INSURANCE INFORMATION | | | |
|---|---|---|---|
| **PRIMARY INSURANCE CARRIER:** | | | |
| Subscriber ID/Member No: | | Subscriber ID/Member No: | |
| Address: | City: | ST: | Zip Code: |
| Phone Number: | Policy Holder: | | Policy Holder DOB: |
| **SECONDARY INSURANCE CARRIER:** | | | |
| Subscriber ID/Member No: | | Group/Policy No: | |
| Address: | City: | ST: | Zip Code: |
| Phone Number: | Policy Holder: | | Policy Holder DOB: |

☐ By signing this form I agree and consent to A New Creation Women's Clinic use and disclosure of my protected health information to conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in the treatment directly and indirectly, and to conduct normal healthcare operations such as quality assessment and healthcare provider certifications as stated in the notice of privacy practices, and that I have been provided or offered a copy of this notice.

I agree that all of the above demographic and insurance information is accurate and up to date. If there is an error in the information above, I understand I am responsible for the charges related to the error(s). I understand and agree that regardless of my Insurance status that I am ultimately responsible for the balance of any professional services rendered. I understand that I'm responsible for and charges incurred if my account is sent to a collections agency and for any returned checks. I understand that Medicare and/or other Insurance Carriers do not cover all office services and procedures. I agree to take full responsibility for any unpaid balances and that such payment will be made to the said assignee for services. I hereby assign all medical and/or treatment benefits including major medical benefits to A New Creations Women's Clinic for services rendered.

Print Name:_____Date:_____Signature:_____

Date Signed: _____

**No Show Cancellation Policy:**

A No Show Appointment is an appointment you do not arrive to. It is our policy to charge a $50.00 fee for a No Show appointment. If an emergency arises and you are unable to make the appointment and you call or notify us, it will be reviewed with the Clinical Coordinator and the fee may be waived in some circumstance. Non notification of a missed appointment results in a charge.

Cancellations must be made 24 hours in advance. If the appointment is canceled the same day there will also be a $50.00 fee for the late cancellation.

A patient who arrives 10 minutes late for an appointment will need to reschedule the appointment.

We ask that all patients sign this policy to be kept in your file.

Print Name:_____Signature:_____

**Insurance Disclaimer:**

Although we make every attempt to verify coverage prior to your appointment, you may have a deductible to pay AND/OR your insurance may not completely cover your office visit or other fees associated with your care including procedures, supplies or phone consultations. Fees are charged based on time and level of service.

Print Name:_____Signature:_____

**Medicare Waiver (Sign only if you have Medicare):**

Medicare will only pay for services that it determines to be reasonable and necessary under Section 1862 (1)(1) __ of the Medicare Law. If Medicare determines that a particular service, although it would otherwise be covered is not reasonable and necessary under Medicare program standards, Medicare will deny payment for that service. I believe that in your case Medicare is likely to deny payment for:

1. Annual exam with Pap once every two years
2. Medicare does not cover Birth control
3. Medicare does not cover most preventative services. Preventative services are rendered when you have already received your annual exam with Pap smear in the last two years. For patients receiving these services advanced beneficiary notices are not requires. According to Medicare guidelines, patients can be billed directly. Preventive services include an annual exam with pap smear.
4. Medicare only covers physical within the first six months of signing up with Medicare, otherwise it is the patients responsibility.

**Please read and sign the following statements:** I have been informed by my Provider that she believe that in my case, Medicare is likely to deny payment for services identified above, for the reason stated. If Medicare denies payment, I agree to be personally and fully responsible for the payment.

Print Name:_____Signature:_____

## 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 read carefully.

This notice describes how we many use and disclose your health information about you as a patient of this practice.
A New Creation Women's Clinic understand that your health information is personal and we are committed to protecting your privacy and ensuring your health information is used appropriately. We are required by law to maintain the privacy of your health information. We may use and disclose your information only for each of the following purposes: treatment, payment and healthcare operations.

Treatment: To provide you with medical treatment or services, we may also disclose your information to another healthcare provider to be sure that the party has all the information they need to diagnose and treat you.

Payment: We may disclose your information to others so they will pay or reimburse you for your treatment.

Individuals involved in your care or payment for you care: We may release your health information, including information about your condition to a family member, or friend who is involved in your care or helps you pay for your care if they are named and authorized in your chart.

As required by law: We will disclose medical information about you without consent when required to by federal, state or local law.

Judicial and Administrative Processing: Lawsuits and similar proceedings in response to a court or administrative order.

Serious threat to health or safety: If there is a serious threat to your health or safer or the health and safety of the public or another person, we may use and disclose your health information to someone else to prevent the threat.

Law Enforcement: If required to do so by a law enforcement official.

Public Health Activities: To public health authorities oversight agencies that are authorized by law to collect information.

Workers Compensations: For workers compensation or similar programs. These programs provide benefits for work related injuries or illnesses.

Military and Veterans Activities: To authorize federal officials for intelligence, counter intelligence and other national security activities authorized by law.

Inmates: To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.

Other Uses and Disclosures of your Health Information: Other uses of your health information not covered by this notice or the laws that apply to us will be made only with your authorization. If you authorize us to use or disclose your information you may revoke that authorization, in writing, at any time. If you revoke your authorization we will no longer use or disclose your information as specified by the revoked authorization, except to the extent that we have taken action in reliance on your authorization.

Your Rights Regarding Your Health Information: You have the following rights regarding the information we retain about you.

Right to Request Restriction: You have the right to request restrictions on how we use and disclose your health information for treatment, payment or health care operations. We are not required to agree to your request. If we do agree we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions you must make it ins rioting and submit it to our Clinical Coordinator.

Right to inspect and Copy: You have the right to inspect and copy health information that may be used to make decisions about your care. Usually this included medical and billing records but does not include psychotherapy notes or info ration that is complied in reasonable anticipation of or use in civil, criminal or administrative action or processing. To inspect and copy your health records, you must make your request in writing and submit it to our Clinical Coordinator. If you request a copy of your health information we may charge you the fee for the costs of copying, mailing or preparing the documents.

Right to Amend: If you feel that your health information is incorrect or incomplete, you may request that we amend your information. You have the right to request an amendment for as long as the information is kept by or for us. To request amendment you must make your request in writing by filling out the appropriate forms and submitting them to our Clinical Coordinator. We may deny your request for an amendment. If this occurs you will be notified of the reason fro the denial and given the opportunity to file a written statement of disagreement with us.

Right to a paper copy of this Notice: You have a right to a paper copy of this notice at any time.

Right to provide an authorization for other uses and disclosures. Our Practice will obtain your written authorization for uses and disclosures that are not identified in this notice or Permitted by applicable law.

Complaints: If you believe your privacy rights have been violated you may file a complaint with this office or with the Secretary of the DEPT. OF HEALTH AND HUMAN SERVICE. To file a complain with the office, contact our Clinical Coordinator at 3055 W. Ina Rd. Suite 195, Tucson, AZ 85741, 520-293-1117

Print Name:_____Date:_____Signature:_____

## Patient's Bill of Rights and Responsibilities

**As a patient you have the right to:**

- Considerate and respectful care
- Knowledge of the name of the healthcare providers who has primary responsibility for coordinating the care, and the names professional relationships of any other healthcare providers who may see you.
- Receive as much information about any proposed treatment or procedure as your may need in order to give informed consent or to refuse this course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved in this treatment, alternative course of treatment or non-treatment and the risks involved in each and know the name of the provider who will carry out the procedure or treatment.
- Participate actively in any decisions regarding your medical care; to the extent permitted by law, this includes the right to refuse treatment.
- Full consideration of privacy concerning your medical care. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly. You have the right to be advised as to the reason for the presence of any individual.
- Confidential treatment of all communication and records pertaining to your care.
- Reasonable continuity of care and to know, in advance, the time and location of the appointment as well as the identity of the persons providing the care.
- Be advised if the healthcare provider proposes to engage in or perform human experimentation affecting care or treatment, you have the right to refute to participate in such research projects.
- Have all your rights apply to the person who may have legal responsibility to make decisions regarding medical care on behalf of the patient.
- Have complaints forwarded to Administrative personnel for appropriate response.
- Know that all the Clinic/Office personal will observer your rights.

**The care a patient receives depends partially on the patient. Therefore, in addition to patient rights, you as a patient have certain responsibilities.**

- You are responsible to provide accurate and complete information conceding your present complains, past medical history, and other matters relating to your health.
- You are responsible for making it known whether you clearly comprehend the course of your medical treatment and what is expected of you.
- You are responsible for following the treatment plan established for you by your healthcare provider, including the instructions of Medical Assistants and other health professionals as they carry out the healthcare providers orders.
- You are responsible for keeping appointments and for notifying the office within 25 hours to cancel your appointment. We understand emergency situations occur, however, we reserve the right to initiate a $50.00 missed appointment fee per occurrence, with the possibility of dismissal after three occurrences.
- You are responsible for your actions should you refuse treatment or not follow the healthcare providers orders/recommendations.
- You are responsible for assuring that the financial obligations of your care are fulfilled.
- You are responsible for being considerate of the rights of other patients and office personnel.

**I understand my rights and responsibilities as a patient of A New Creation Women's Clinic.**

Patient Signature:_____Date:_____

Witness:_____Date:_____

# PATIENT QUESTIONNAIRE

Print Name:_____

| PHARMACY INFORMATION | |
|---|---|
| Preferred Pharmacy | Secondary (Compound) Pharmacy |
| Name: | Name: |
| Address: | Address: |
| Phone: | Phone: |
| Fax: | Fax: |

**MEDICATIONS -** List All Medications You Take - Prescription and Non-Prescription & Dose

☐ I Do Not Take Any Medications

| Medication Name | Dosage |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |

**MEDICATIONS -** List All Known Allergies (Drugs, Food, Environmental)

☐ No Known Allergies

| | |
|---|---|
| | |
| | |
| | |

**MEDICAL HISTORY -** Check if You Are Currently Experiencing

**General:** ☐Fever ☐Unintentional Weight Loss ☐Decreased Appetite

**Eyes:** ☐Visual Changes ☐Cataracts ☐Glaucoma

**Ears/Nose/Throat:**
☐Ear Aches ☐Difficulty Hearing ☐Frequent Nose Bleeds
☐Persistent Nose Bleeds ☐Sore Throat
☐Swollen Glands ☐Neck Stiffness

**Respiratory:** ☐Cough ☐Phlegm Production ☐Wheezing ☐Shortness of Breath ☐Pain with Breathing

**Gastroenterology:**
☐Nausea ☐Vomiting ☐Diarrhea ☐Constipation
☐Abdominal Pain ☐Bloody Stools ☐Black Stools
☐Heartburn/Ulcers ☐Liver Problems ☐ Pancreatic Problems

**Musculoskeletal:**
☐Fractures/Dislocation ☐Joint/Pain ☐Joint Swelling
☐Arm/Leg Weakness ☐Arm/Leg Numbness

**Skin/Integument:**
☐Rashes or Hives ☐Itching ☐Ulcers

**Endocrine:** ☐Blood Sugar Problems ☐Thyroid Problems ☐Changes in Voice ☐Steroid Use

**Hematologic:** ☐Anemia ☐Abnormal Bleeding ☐Blood Transfusions

**Cardiovascular:**
☐Palpitations/Irregular Pulse ☐Angina/Chest Pain
☐Heart Attack ☐Increased Blood Pressure
☐Increased Cholesterol

**Genitourinary:**
☐Painful Urination ☐Frequent Urination ☐Urinary Incontinence
☐Blood in Urine ☐Frequent Urinary Infections ☐Change in Libido
☐STD ☐Genital Pain/Discharge/Itching

**Gynecologic:**
☐Hot Flashes ☐Irregular Periods ☐Very Heavy Periods
☐History of HPV ☐History of Abnormal Pap Date:_____

**Neurological:**
☐Significant Headaches ☐Confusion ☐Dizziness
☐Balance Problems ☐Memory Loss

**Psychiatric:**
☐Depression ☐Inability to Concentrate ☐Dizziness
☐Frequent Insomnia ☐Suicidal Tendencies

# PATIENT QUESTIONNAIRE

Print Name:_____

| SURGICAL HISTORY | | | |
|---|---|---|---|
| Surgical Procedure | Date | Surgical Procedure | Date |
| None | | Breast Implant Enlargement | |
| Appendectomy | | Bilateral Tubal Ligation (Sterilization) | |
| Back Surgery | | Breast Biopsy | |
| Carpal Tunnel Release | | ☐ Cesarean Section | |
| Cataract Extraction | | ☐ Colposcopy (Biopsy of the Cervix) | |
| Cholecystectomy (Gall Bladder) | | ☐ D and C | |
| Gastric Bypass | | ☐ Hysterectomy (Partial or Full) Vaginal / Abdominal | |
| Hernia Repair | | ☐ Mastectomy | |
| Hip Replacement | | ☐ Myomectomy | |
| Knee Replacement | | ☐ Breast Reduction | |
| LASIK | | ☐ Other:_____ | |
| Thyroidectomy | | ☐ Other:_____ | |
| Tonsillectomy | | ☐ Other:_____ | |

| **HEALTH MAINTENANCE -** Check if You have Received the Following & Date of Most Recent Exam | | | |
|---|---|---|---|
| Exam | Date | Exam | Date |
| ☐ None | | ☐ Influenza Vaccine | |
| ☐ Cardiac Stress Test | | ☐ Pneumococcal Vaccine | |
| ☐ Echocardiogram | | ☐ Tetanus Vaccine | |
| ☐ EKG | | ☐ Shingles Vaccine | |
| ☐ Colonoscopy | | ☐ Physical Exam | |
| ☐ Pulmonary Function Test | | GYN Exam | |
| ☐ Eye Exam | | ☐ PAP Test | |
| ☐ FOBT (Stool Card) | | ☐ Mammogram | |
| ☐ Cholesterol | | ☐ Breast Exam | |
| | | ☐ DEXA Exam | |

# PATIENT QUESTIONNAIRE

Print Name:_____

| **FAMILY HISTORY -** Check if any Family Members(s) has had any of the following Conditions | | | | | | |
|---|---|---|---|---|---|---|
| | | Adopted | Unknown | | | |
| Diagnosis | Mother | Father | Brother | Sister | Other | Other |
| Alzheimer's Disease | | | | | | |
| Asthma | | | | | | |
| Autoimmune (Lupus, MS, RA) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| CAD (Heart Attack) | | | | | | |
| Cancer-Type:_____ | | | | | ☐ | |
| CVA (Stroke) | | | | | | ☐ |
| Depression | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Diabetes | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Hyperlipidemia (High Cholesterol) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Hypertension (High Blood Pressure) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Arthritis | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Osteoporosis | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Other:_____ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

## REPRODUCTIVE HISTORY

Age of First Period:_____ | How Often Do You Get Your Cycle? Every_____ Days, Lasting_____ Days

Are Your Cycles? ☐Regular ☐Irregular | If Menopausal, Age of Menopause_____ | Are You Sexually Active? ☐Never ☐Not Currently ☐Yes

Method of Contraception: Not Needed ☐Vasectomy ☐Rhythm Method ☐Implanon ☐Tubal Ligation
☐None ☐Condoms ☐NuvaRing ☐Mirena IUD ☐ParaGuard IUD ☐Essure ☐Pill ☐Patch ☐Depo Provera

Total Pregnancies_____ Live Births_____ Terminations_____ Miscarriages_____

Hysterectomy ☐YES ☐NO Vaginal or Abdominal Do You Still Have Ovaries? ☐YES ☐NO

## SOCIAL HISTORY

Occupation:_____ | Employer:_____

Are You? ☐Married ☐Single ☐Engaged ☐Significant Other ☐Divorced ☐Widowed ☐Same Sex Partner

Significant Other's Name:_____ Phone Number:_____

Other Emergency Contact Name:_____ Phone Number:_____

Tobacco Use? ☐Never ☐Current # of Cigarettes per day_____ ☐Former, Quit Age_____

Alcohol Use? ☐YES ☐NO *If yes, the average number of drinks per week:_____

Do you use Recreational Drugs? ☐YES ☐NO *If yes, the type used and last use: _____

How many times and how long per week do you exercise? ☐1x ☐2x ☐3x ☐4x ☐5x ☐6x ☐7x
Per Session: ☐20 mins ☐30 mins ☐45 mins ☐60+ mins

Diet? ☐Regular ☐Vegetarian ☐Vegan ☐Gluten Free ☐Other:_____

Does a Partner or Anyone at home hurt, hit, or threaten You? ☐YES ☐NO
Would you like more information today about Domestic Violence and a Safe Place to go? ☐YES ☐NO

Patient Signature:_____Date:_____