2006 Brookwood Medical Center Drive • Women's Medical Plaza
Suite 600 • Birmingham, Alabama 35209
Phone (205) 877-2971 • Fax (205) 877-2964
Janet A. Davis, MD Karla Kennedy, MD Beth A. Barron, MD Margot Gathings, MD

Patient Information _____ **Preferred Physician**_____

Last Name: _____ First _____ Middle _____

Preferred: _____ DOB: _____ Sex:_____

Social Security Number: _____

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ White ☐ Other ☐ Decline to report

Ethnicity: ☐ Hispanic/Latino ☐ not Hispanic/not Latino ☐ Decline to report

Preferred Language: ☐ English ☐ Spanish ☐ Other_____

Marital status: S / M / D / W **Spouse's Name**_____

Address: _____

Zip: _____ City: _____ State: _____ County: _____

Phone: Home: _____ Work: _____ Cell: _____

Fax: _____ Email: _____

Preferred Communication: ☐ Home ☐ Work ☐ Cell ☐ Email ☐ Text

Primary Physician_____ **Referring Physician**_____

Preferred Pharmacy: **I consent to allow Women's Care Specialist to retrieve my prescription history from my pharmacy:** ☐ Yes ☐ No

Name: _____

Address: _____

Phone: _____

Employer: _____ Occupation: _____ Work Phone:_____

Phone or Ext: _____

Emergency Contact:

Name:_____ Relationship:_____ Phone:_____

Insurance Information:

Primary_____ ID#_____ Group#_____

Subscriber_____ Relationship_____ DOB_____

Secondary_____ ID#_____ Group#_____

Subscriber_____ Relationship_____ DOB_____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I authorize payment of any medical benefits to the physician providing the medical services submitted for payment that would have otherwise bee payable to me. I understand that any amount deemed by my insurance carrier to be beyond the "usual, reasonable and/or customary" charges for said services will be paid by me.

ATTENTION MANAGED CARE ENROLLEES (PMS, UNITED HEALTHCARE, ETC.): I understand that some procedures done by my individual physician and approved by me are not covered by my individual contract. I accept the responsibility for the immediate payment of the charges not covered by my insurance company and agree to pay attorney's fee, court costs, and any other reasonable costs of collection should I fail to make payment.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the physicians of Women's Care Specialists, P.C. to release any information acquired in the course of my examination or treatment to my insurance company. My medical information includes any and all records related to my diagnosis, treatment, and care, including but not limited to testing which may include HIV and HBV test results.

PAYMENT TERMS: You will receive two statements on balances due before we start active collections on your account. Any balance written off to bad debt must be paid before receiving routine care, including prescriptions.

- As consideration for the Physician's services, I agree to pay all charges for services at the completion of such services. If payment is not received upon completion of treatment, the Physician may, at his/he discretion, place the unpaid account with an attorney for collection. If this action is necessary, I agree to pay an attorney's fee, court costs, and any other reasonable cost of collection.
- I understand that a check returned by my bank for any reason is subject to a reasonable service charge.
- I have read and understand the above statements.

WOMEN'S CARE SPECIALISTS, P.C.
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ACKNOWLEDGEMENTS - Please initial each disclaimer and sign.

Preventive Services Disclaimer – I have reviewed the Preventive Services Disclaimer displayed in the waiting area and I understand that my insurance may apply a co-payment for any additional services rendered outside the scope of the Preventive Services provided by the Affordable Care Act. Initials _____

Formulary Benefits Data – We ask your permission to obtain formulary information, and information about other medications prescribed by other providers using SureScripts. A detail explanation regarding this request in displayed in our waiting area. Initials _____

Notice Of Privacy Practices - I acknowledge by signing below that I have received the Notice of Privacy Practices and Notice of Individual Rights of Women's Care Specialist, P. C. Initials _____

CONSENT FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR PAYMENT, TREATMENT AND HEALTH CARE OPERATIONS

By signing below, you hereby consent for this Practice to use or disclose information about yourself (or another person for whom you have the authority to sign) that is protected under federal law, for the sole purposes of treatment, payment and health care operations. You have the right to revoke this consent. By signing below, you recognize that the protected health information used or disclosed pursuant to this Consent may be subject to re-disclosure by the recipient and may no longer be protected under federal law.

There is no expiration date for this Consent.

You may communicate with the following individuals regarding my condition or course of treatment, invoices for services, appointment reminders and test results:

_____

You may communicate confidential information to me regarding my conditions or course of treatments, invoices for services, appointment reminders and test results to the following address, e-mail or phone number:

_____

_____ _____
Individual Signature Date

As a personal representative, I have authority to act for the individual because I am the individual's _____

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PATIENT HISTORY FORM

NAME:_____ **DATE OF BIRTH:**_____

Have you been hospitalized or had any procedure since your last check-up? ☐ **Yes** ☐ **No**
If yes, please describe: _____

_____

PERSONAL MEDICAL HISTORY: (Please circle those that apply to your own medical history)

ADD
Anemia
Arthritis
Type: Rheumatoid/Osteo/Other
Asthma/COPD
Bleeding Disorder
Breast Cancer
Cancer/Type:_____
_____
Cervical Cancer
Clotting/Bleeding Disorder
Type:_____
Crohn's Disease
Depression
Diabetes
DVT (Deep Vein Clot)
Esophageal Reflux (GERD)
Fibromyalgia
Glaucoma
Heart/Coronary Artery Disease
Hepatitis
HIV
Hypercholesterolemia
Hypertension (High BP)
Hyperthyroid (overactive)
Hypothyroid (underactive)
Irritable Bowel Syndrome (IBS)
Kidney Disease
Kidney Stones
Lupus
Migraines
Mitral Valve Prolapse
Multiple Sclerosis
Osteopenia
Osteoporosis
Polycystic Ovary Synd
Pulmonary Embolus
Sickle Cell Anemia
Sleep Apnea
Stroke/TIA
Ulcerative Colitis

OTHER:_____
_____

If Applicable: Last Menstrual Period_____ **Hysterectomy**_____
Abnormal Pap_____

PAST SURGERIES:_____ _____
_____ _____
_____ _____
_____ _____

MEDICATIONS: _____

_____

_____

ALLERGIES (Medications, Latex, Iodine, IV contrast media): None Known / YES. Please List:

_____

FAMILY HISTORY: Abbeviation: M (mother), F (father), B (brother), S (sister), MGM (maternal grandmother), PGM (paternal grandmother), MGF (maternal grandfather), PGF (paternal grandfather), MA (maternal aunt), PA (paternal aunt), PU (paternal uncle), MU (maternal uncle)

Alzheimer's_____
Bladder Cancer_____
Bone Cancer_____
Breast Cancer_____
Colon Cancer_____
Diabetes_____
Esophageal Ca_____
Heart Disease_____
Hypertension_____
Kidney Cancer_____
Leukemia_____
Liver Cancer_____
Lung Cancer_____
Lymphoma_____
Melanoma_____
Osteoporosis_____
Ovarian Cancer_____
Pancreatic Ca_____
Prostate Ca_____
Stroke_____
Testicular Cancer_____
Thyroid Cancer_____
Uterine Cancer_____
Vagina/Vulva Ca_____
Other_____

OB HISTORY

Have you been pregnant before? Yes / No
Total pregnancies_____
Full term deliveries_____
Preterm deliveries (<37 weeks)_____
Miscarriages_____
Ectopic/Tubal pregnancies_____
Elective Terminations_____
Living Children_____
Vaginal births_____
C-sections

SOCIAL HISTORY

Alcohol: never / social / daily
Smoking: never / current / former
If current, how much?_____
Marital status: S / M / D / W
Occupation:_____

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ANTEPARTUM GENETIC SCREENING

PatientName_____ DOB:_____

Fathers Name:_____

Obstetrical History:

Total # pregnancies_____/Term_____/Premature_____Loss_____/#Living Children_____

Date M/D/Y	Gestational Age	Birth Weight	Sex	Type of Delivery	Anesthesia	Complications Comment	Name of child

Genetics Screening - Includes Patient, Baby's Father or Anyone in Either Family

Patient's age greater than 35 years?	☐ Yes ☐ No
Thalassemia	☐ Yes ☐ No
Neural Tube Defect (spina bifida, anencephaly)	☐ Yes ☐ No
Congenital Heart Defect	☐ Yes ☐ No
Down's Syndrome	☐ Yes ☐ No
Tay-Sachs Disease	☐ Yes ☐ No
Canavan Disease	☐ Yes ☐ No
Sickle Cell Disease or Carrier	☐ Yes ☐ No
Hemophilia or Blood Disorder	☐ Yes ☐ No
Muscular Dystrophy	☐ Yes ☐ No
Cystic Fibrosis	☐ Yes ☐ No
Huntington's Chorea	☐ Yes ☐ No
Mental retardation/Autism	☐ Yes ☐ No
If yes, was person tested for Fragile X	☐ Yes ☐ No
Other inherited genetic or chromosomal disorder	☐ Yes ☐ No
Maternal metabolic disorder (for example PKU)	☐ Yes ☐ No
Patient or baby's father had a child with birth defect	☐ Yes ☐ No
Recurrent pregnancy loss or a stillbirth	☐ Yes ☐ No
Medications or street drugs since last mentrual period	☐ Yes ☐ No

If yes - Agents:_____

Infection History

HIV/Aids risk assessment	☐ Yes ☐ No
High risk Hepatitis B	☐ Yes ☐ No
Hepititis B immunized	☐ Yes ☐ No
Live with someone with TB or exposed to Hepatitis B	☐ Yes ☐ No
Patient or partner have history of genital herpes	☐ Yes ☐ No
Rash or viral illness since last mentrual period	☐ Yes ☐ No
History of STD, GC, Chlamydia, HPV, Syphilis	☐ Yes ☐ No

Women's Care Specialists, P.C.
Notice of Privacy Practices

Form 7.20

This notice describes how medical information about you may be used and disclosed, and how you can gain access to this information. Please review it carefully.

Protected health information (PHI), about you, is maintained as a written and/or electronic record of your contacts or visits fo healthcare services with our practice. Specifically, PHI is information about you, including demographic information (i.e., name, address, phone, etc.), that may identify you and relates to your past, present or future physical or mental health condition and related healthcare services.

Our practice is required to follow specific rules on maintaining the confidentiality of your PHI, using your information, and disclosing or sharing this information with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control your PHI. It also describes how we follow applicable rules and use and disclose your PHI to provide your treatment, obtain payment for services you receive, manage our healthcare operations and for other purposes that are permitted or required by law.

Your Rights Under The Privacy Rule

Following is a statement of your rights, under the Privacy Rule, in reference to your PHI. Please feel free to discuss any questions with our staff.

You have the right to receive, and we are required to provide you with, a copy of this Notice of Privacy Practices - We are required to follow the terms of this notice. We reserve the right to change the terms of our notice, at any time. Upon your request, we will provide you with a revised Notice of Privacy Practices if you call our office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment. The Notice will also be posted in a conspicuous location within the practice, and if such is maintained by the practice, on it's web site.

You have the right to authorize other use and disclosure - This means you have the right to authorize any use or disclosure of PHI that is not specified within this notice. For example, we would need your written authorization to use or disclose your PHI for marketing purposes, for most uses or disclosures of psychotherapy notes, or if we intended to sell your PHI. You may revoke an authorization, at any time, in writing, except to the extent that your healthcare provider, or our practice has taker an action in reliance on the use or disclosure indicated in the authorization.

You have the right to request an alternative means of confidential communication – This means you have the right to ask us to contact you about medical matters using an alternative method (i.e., email, telephone), and to a destination (i.e., cell phone number, alternative address, etc.) designated by you. You must inform us in writing, using a form provided by our practice, how you wish to be contacted if other than the address/phone number that we have on file. We will follow all reasonable requests.

You have the right to inspect and copy your PHI - This means you may inspect, and obtain a copy of your complete health record. If your health record is maintained electronically, you will also have the right to request a copy in electronic format. We have the right to charge a reasonable fee for paper or electronic copies as established by professional, state, or federal guidelines.

You have the right to request a restriction of your PHI - This means you may ask us, in writing, not to use or disclose any part o your protected health information for the purposes of treatment, payment or healthcare operations. If we agree to the requested restriction, we will abide by it, except in emergency circumstances when the information is needed for your treatment. In certain cases, we may deny your request for a restriction. You will have the right to request, in writing, that we restrict communication to your health plan regarding a specific treatment or service that you, or someone on your behalf, h paid for in full, out-of-pocket. We are not permitted to deny this specific type of requested restriction.

You may have the right to request an amendment to your protected health information - This means you may request an amendment of your PHI for as long as we maintain this information. In certain cases, we may deny your request.

You have the right to request a disclosure accountability - This means that you may request a listing of disclosures that we have made, of your PHI, to entities or persons outside of our office.

You have the right to receive a privacy breach notice - You have the right to receive written notification if the practice discovers a breach of your unsecured PHI, and determines through a risk assessment that notification is required.

If you have questions regarding your privacy rights, please feel free to contact our Privacy Manager. Contact information is provided on the following page under Privacy Complaints.