

# Arizona Maternity & Women's Clinic

## Patient Information

Patient Name: (Last, First, Middle)		**Email:(PLEASE PRINT)	
Street Address:	City:	State:	Zip:
** Home phone: (    )    -	Patient Marital Status:		Ethnicity:
**Cell Phone: (    )    -	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> other		
Birthdate:	** <u>Social Security #</u>	Patient Employment Status: _____	
Pharmacy:		Address/cross roads:	
Patient Employer:		Employer's Phone Number:	
Primary Care Physician:	Referred by:	Do you have: <input type="checkbox"/> Living Will <input type="checkbox"/> Medical Power of Attorney	
Emergency contact: Name: _____ Telephone number: _____			
Address: _____ Relationship to Patient: _____			
<b>** What is your preferred method of contact to confirm your future appointment, and to receive normal results?</b> <input type="checkbox"/> Phone <input type="checkbox"/> Text <input type="checkbox"/> Email			

**Primary insurance:**

Insurance name:	Policyholder's name:		
Policyholder's birth date:	ID number:	Group number:	

**Secondary insurance:**

Insurance name:	Policyholder's name:		
Policyholder's birth date:	ID number:	Group number:	

ASSIGNMENT AND RELEASE: I hereby assign my insurance benefits to be paid directly to Arizona Maternity & Women's Clinic. I understand that I am financially responsible for any non-covered services. I also authorize AMWC to release any information required to process this claim. I certify that the information provided above is true and correct to the best of my knowledge. I will promptly notify Arizona Maternity & Women's Clinic Inc of any changes to this information.

**Sign:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**ARIZONA MATERNITY & WOMEN'S CLINIC**

**Permission to release medical information:**

I \_\_\_\_\_, give my consent to have my medical information, including labs, x-rays, and any pertinent information given to \_\_\_\_\_,  
My \_\_\_\_\_ (spouse, guardian, other)

\_\_\_\_\_  
\_\_\_\_\_

IF NO ONE PLEASE CHECK

**Is it ok to leave a voicemail regarding any normal test results?**

If YES please check

If NO please check

If YES, what is the best number? \_\_\_\_\_

This consent is valid for one (1) year unless consent is revoked in writing.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## Arizona Maternity & Women's Clinic

### FINANCIAL RESPONSIBILITY

Arizona Maternity & Women's Clinic accepts cash, Visa, and Master card as payment for services provided. **Please remember, it is the patients responsibility to know exactly what their insurance benefits are, and if a referral is needed to see our providers. If you have any concerns regarding your insurance coverage please contact your insurance carrier.** Our financial policy is as follows:

- **Insurance co-payments:** **MUST** be paid at the time services are rendered. Please be aware that co-payments might vary between primary care physician and specialist physician. Please check with your insurance carrier if you have any concerns.
- **No show fee:** Our office does attach a fee for broken appointments or failure to cancel within 24 hours notice. Charges are \$25.00 for provider's appointment and \$50.00 for ultrasound appointment. (If both appointments are missed on the same day the single fee of \$50.00 applies)
- **Deductibles/ Co-insurance:** If your deductible has not been met, full payment of the deductible may be required at the time of services along with any applicable co-insurance amount.
- **Private pay/ Non-contracted Insurance companies:** If you do not have insurance coverage or have coverage with an insurance we are not contracted with, you will be responsible for payments in full at the time of the service.
- **Laboratory services:** Lab services will be billed by the lab with which they were sent. We bill your insurance for specimen collection only. You may receive a bill form the lab for any coinsurance or deductible that may have been applied.
- **Collection policy:** if your account is placed with a collection agency, all future visits would require payment in full at the time of service. You will be help fully accountable for any collection agency fees and/or attorney fees that are acquired in the recovery of this debt. These fees are over and above the original balance due.
- **Return Checks:** A \$30.00 fee will be added to your account for any returned checks.

It is very important to stay well informed about your insurance coverage. If you have a new insurance, it is your responsibility to provide an updated card. You will be held responsible for the total amount of any unpaid claims that are denied for incorrect insurance information.

Printed name of patient /guarantor \_\_\_\_\_

Signature of patient /guarantor \_\_\_\_\_

Date: \_\_\_\_\_

## Service Agreement

The patient or patient's authorized agent or representative, agrees to the following terms of service.

**Consent to treatment:** The patient voluntarily agrees to be evaluated/treated by the provider. This consent is valid and continuing until the patient is discharged from Arizona Maternity & Women's Clinic.

**Release of information:** Provider may release all or any part of the patient's medical records to the persons or entities engaged in the activities stated below:

- A. Insurance and Quality Review: Persons or corporations (including insurance companies, worker's compensation payers, hospitals or medical service corporations, welfare funds, governmental agencies or the patient's employer), or their designees, which may be liable under contract to the provider, any other party, the patient, a family member, or employer of the patient, for the purposes of securing payments of all or part of the provider's charges, and quality assurance, accrediting agencies, and provider and physician liability insurance carriers to enable them to carry out their functions.
- B. Billing and Collections: Agents or employees of the provider that process or duplicate medical records for billing and reimbursement process.
- C. Medical Audit: Persons or entities authorized by the Provider for purposes of conducting medical audit activities.
- D. Other Providers: Physicians and personnel involved in the patient's care to provide and manage the patient's healthcare. Also, information may be given to other health care providers to assure continuity of care.

I understand that I may revoke this authorization at any time, except to the extent the provider has acted in reliance upon it or the disclosure is authorized by law. This consent to the release of patient information remains valid until expressly revoked by the patient in writing.

**Financial agreement:** the patient agrees, in return for serviced provided to pay her account balance in full or to make arrangements for payments which are satisfactory to the provider. To the extent not expressly prohibited by applicable law, the patient agrees to pay all charges not paid in full by her insurance carrier or a third party carrier. The patient also agrees to pay reasonable attorney fees and collection expenses if the account is sent to an attorney for collections.

**Assignment if insurance benefits:** if patient is entitled to any policy of insurance which insures the patient, or any party liable to the patients, then the patient hereby assigns all such benefits to be applied to the provider. It is understood, however, the patient remains responsible for payments her bill in full regardless of patients assignment of insurance coverage. I understand that I am responsible for my health insurance deductions and co-payments.

**Price quote:** The patient understands that any price quotation given are estimates of expected services and not a guarantee.

**Medicare patients:** The undersigned certifies that all information given in applying for payment under title XVIII of the Social Security Act is correct. Patient requests that payment of authorized benefits, when received, be made to the provider. Patient authorizes release of any information needed to act on this request.

THE UNDERSIGNED CERTIFIES THAT 1. I HAVE READ AND UNDERSTAND THESE CONDITIONS OF SERVICE, 2. I HAVE RECEIVED A COPY AND 3. I AM THE PATIENT OR AM DULY AUTHORIZED BY THE PATIENT AS A PATIENT'S AGENT TO SIGN THIS AGREEMENT AND ACCEPT ITS TERMS.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

PATIENT OR PATIENT'S AGENT OR REPRESENTATIVE

RELATIONSHIP TO PATIENT: \_\_\_\_\_

GYNECOLOGY HEALTH HISTORY-PAGE 1

TODAY'S DATE: \_\_\_\_\_

Patient name: \_\_\_\_\_

Date of birth: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

Medication allergies:

\_\_\_\_\_

Please list the reason(s) for your appointment today:

\_\_\_\_\_  
\_\_\_\_\_

Duration:

\_\_\_\_\_

**Obstetrical History:** please list the number of each of the following;

Of pregnancies \_\_\_\_\_ of children \_\_\_\_\_ of miscarriages \_\_\_\_\_ of abortions \_\_\_\_\_ of ectopic \_\_\_\_\_

When was your last **BONE SCAN**? \_\_\_\_\_ History of ABNORMAL DEXA: yes/no

When was your last **PAPSMEAR**? \_\_\_\_\_ History of ABNORMAL PAPSMEARS: yes/no

Have you ever been diagnosed with **HPV**? yes/no

When was your last **MAMMOGRAM**? \_\_\_\_\_ History of ABNORMAL MAMMOGRAMS: yes/ no

**Menstrual History:**

When was your **last menstrual period**? \_\_\_\_\_

Your age at **first menstrual period**? \_\_\_\_\_

Are your menstrual periods **regular or irregular**? \_\_\_\_\_

How often are your periods? \_\_\_\_\_

How many days does your period last: \_\_\_\_\_

Menstrual flow: \_\_\_ Light \_\_\_ Moderate \_\_\_ Heavy

Do you have **cramps** with your period? yes/no

If yes, do you need **medication for relief**? yes/no If yes, **what medication**? \_\_\_\_\_

If you are not having a menstrual period, at what age did you have your last one? \_\_\_\_\_

Have you ever had a **hysterectomy**? yes/no

Since menopause; any **vaginal bleeding**? yes/no.

Do you have **hot flashes**? yes/no **Vaginal dryness**? yes/no

**Sexual History:**

How many sexual partners have you had? \_\_\_\_\_

Are you sexually active at the present time? yes/no

Have you been sexually active with **more than one partner** in the past six months? yes/no

Do you usually have pain with intercourse? yes/no What do you use for birth control? \_\_\_\_\_

Have you ever been physically abused? yes/no Sexually abused? yes/no Received counseling? Yes/no

History of any of the following sexually transmitted diseases?

Trichomonas  Gonorrhea  Herpes  PID  Chlamydia  Syphilis  HIV  HPV

\_\_\_\_\_

**GYNECOLOGY HEALTH HISTORY- PAGE 2**

Past medical history, have you ever had any of the following problems?

**General**

Cancer yes  
Weight gain yes  
Weight loss  yes  
Fatigue yes

**Eyes**

Glaucoma yes

**ENT/Mouth**

Hearing loss yes  
Sinus problems yes  
Dental problems yes

**Cardiovascular**

Hypertension yes  
Heart Attack yes  
Heart palpitations yes  
Heart murmur yes

**Musculoskeletal**

Arthritis yes  
Osteoporosis yes

**Respiratory**

Asthma yes  
Emphysema yes  
Bronchitis yes  
Tuberculosis yes  
Valley Fever yes  
Pneumonia yes

**Gastrointestinal**

Diarrhea, frequent yes  
Ulcers yes  
Jaundice/hepatitis yes  
Constipation yes  
Diverticulitis yes

**Breast**

Tumor/cyst (benign)yes  
Nipple discharge yes

**Psychiatric**

Depression yes  
Post partum  
Depression yes  
Anxiety yes

**Urinary**

Incontinence yes  
Kidney Stone yes  
Blood in urine yes  
urgency yes  
infection/frequent yes

**Neurological**

Seizures yes  
Stroke yes  
Headaches yes

**Endocrine**

Thyroid disease yes  
Diabetes yes  
Gestational Diabetes yes  
Hair loss yes  
Hair growth yes

**Hematological**

Bleeding/Bruising yes  
Anemia yes  
Blood transfusion yes

Any other medical conditions not listed: \_\_\_\_\_

**Medications:** Include dosages and any over the counter medications. (More space on last page)

\_\_\_\_\_  
\_\_\_\_\_

**Past Surgical History:** List ALL operations. (More space on last page)

Year: \_\_\_\_\_ Type of operation: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Social History:**

Marital Status: \_\_\_\_\_ Occupation: \_\_\_\_\_ Previous Occupation: \_\_\_\_\_  
Tobacco: yes/no Alcohol: yes/no Drug Abuse: yes/no Exercise: yes/no Number in household \_\_\_\_\_

**Family History: please clarify rather it is maternal (mother) or paternal (father).**

Breast Cancer yes Who? \_\_\_\_\_  
Ovarian Cancer yes Who? \_\_\_\_\_  
Colon Cancer yes Who? \_\_\_\_\_  
Diabetes yes Who? \_\_\_\_\_  
Heart Disease yes Who? \_\_\_\_\_  
High Blood Pressure yes Who? \_\_\_\_\_  
Stroke yes Who? \_\_\_\_\_

**GYNECOLOGY HEALTH HISTORY- PAGE 3**

Do you have a significant family history of cancer? \_\_\_\_\_  
If yes, please list ALL cancers in your family. \_\_\_\_\_  
\_\_\_\_\_

**PREGNANCY & DELIVERY HISTORY**

Total pregnancies \_\_\_\_\_ Full-term (delivered after 37 weeks) \_\_\_\_\_  
Abortions \_\_\_\_\_ Pre-term (delivery before 37 weeks) \_\_\_\_\_  
Miscarriages \_\_\_\_\_ Twins/Triplets/Multiples \_\_\_\_\_  
Ectopic \_\_\_\_\_

Year	Weight of Baby	Place of Birth	Female/Male	Vaginal/C-section	Weeks at delivery	Problems?	Delivery less than 2 hours?

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## **ARIZONA MATERNITY AND WOMEN'S CLINIC**

**DEAR PATIENT:**

**WE ARE EXCITED ABOUT OUR "PATIENT PORTAL" AND INVITE YOU TO LOGIN AND OBTAIN YOUR USER ID AND PASSWORD. NEW PATIENTS WILL BE SENT THEIR USER ID AND PASSWORD TO THE EMAIL ADDRESS LISTED ON THE DEMOGRAPHIC FORM YOU FILLED OUT. OUR STAFF WILL ENTER YOUR EMAIL ADDRESS AND YOU WILL BE SENT A LINK TO OBTAIN YOUR USER NAME AND PASSWORD.**

**IF YOU ARE AN EXISTING PATIENT WE INVITE YOU TO COMMUNICATE WITH US BY LOGGING IN VIA THE WEB ADDRESS BELOW WITH YOUR USER ID AND PASSWORD. IF YOU HAVE FORGOTTEN USER NAME AND/OR PASSWORD YOU MAY OBTAIN A NEW ONE BY LOGGING ON TO THE PORTAL AS WELL. ONCE ON THE PORTAL YOU CAN VIEW YOUR MEDICAL HISTORY, WHICH INCLUDES PROBLEM LIST, ALLERGIES, LAB/IMAGING! PROCEDURE RESULTS AND MEDICATION LIST.**

**PLEASE LET US KNOW HOW WE ARE DOING! WE VALUE YOUR FEEDBACK!**

**PLEASE LOGIN TO :**

**<https://mycw2o.eclinicalweb.com/portall465/jsp/login.jsp>**

**THANK YOU,**

**ARIZONA MATERNITY & WOMEN'S CLINIC**



# HIPAA NOTICE OF PRIVACY PRACTICES

## SUMMARY AND DISCLOSURE

Arizona Maternity & Women's Clinic

Effective Date: October 12, 2016

Our HIPAA Notice of Privacy Practices describes the privacy practices of Arizona Maternity & Women's Clinic. We respect our legal obligation to keep health information that identifies you private, and by law, we are obligated to provide you a notice of our privacy practices.

We are required by law to maintain the privacy of your health information, to follow the terms of our Notice that are currently in effect, and if you request, to provide you a copy of our Notice regarding our privacy practices and legal duties in respect of you and the information we collect and maintain regarding your health information. Our Notice also describes your rights regarding your health information and certain obligations that mandate how we use and disclose your health information.

### Your Rights – You may:

- Request to inspect any copy of your records.
- Request to amend incomplete or inaccurate information in your records.
- Receive an accounting of certain disclosures of your health information.
- Ask for additional privacy protections (although your request may be declined).
- Ask for confidential communications in a particular manner.
- Receive a paper copy of this Notice.
- File a complaint without penalty.

**Use and Disclosures** – We will not use or disclose your information unless you tell us to do so or unless the law allows or requires us to do so. We use and disclose your information:

- For treatment, payment and health care operations.
- Through patient scheduling; to notify family or a close friend you have entrusted with your care; or for notification after benefits and service.
- For certain activities when the law requires it, such as: public health, reporting of abuse, neglect, or domestic violence; health oversight; lawsuits and disputes; law enforcement activities; coroner; medical examiner, or funeral director purposes; organ donation; avoidance of a serious threat to health or safety; workers' compensation; and national security.
- With your authorization.

**Changes to this Notice** – We reserve the right to change this Notice at any time as allowed by law. Updated Notices will be in our office and paper copies will be available upon request.

**Complaints** – If you believe that we have not properly respected the privacy of your health information, you may file a complaint with our clinic by contacting an Office Manager by calling (623) 547-7205 or by sending a letter to our office address.

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**Please indicate below if we may discuss your health information, billing and/or scheduling with someone you trust:**

**Spouse:** \_\_\_\_\_  Yes, Health Info  Yes, Billing Info  Yes, Scheduling

**Parent/s or Guardian/s:** \_\_\_\_\_ **Indicate Relationship:** \_\_\_\_\_

Yes, Health Info  Yes, Billing Info  Yes, Scheduling

**Relative/Friend/Other:** \_\_\_\_\_ **Indicate Relationship:** \_\_\_\_\_

Yes, Health Info  Yes, Billing Info  Yes, Scheduling

**Acknowledgment of Receipt of this Notice:** As a patient of Arizona Maternity & Women's Clinic, I acknowledge that I have received and seen this notice and understand that I may request a copy of the full HIPAA Notice Privacy Practices for additional information. I understand that Arizona Maternity & Women's Clinic respects their legal obligation to keep health information private unless required by law. My signature below indicates that I agree to these conditions.

Printed Patient Name: \_\_\_\_\_

Signature of Patient: \_\_\_\_\_

Date: \_\_\_\_\_

(Signature of Parent/Guardian if Patient is a Minor)