PATIENT REGISTRATION FORM

LAST NAME _____ **FIRST** _____ **M. I.** _____ **MAIDEN** _____

ADDRESS _____ **PHYSICIAN** _____

CITY, STATE, ZIP CODE _____

HOME PHONE _____ **WORK PHONE** _____ **CELL PHONE** _____

E-MAIL ADDRESS _____ PHARMACY NAME: _____
PHARMACY PHONE: _____

OCCUPATION/EMPLOYER _____

DATE OF BIRTH _____ **SOCIAL SECURITY** _____ **MARITAL STATUS** _____

SPOUSE'S NAME _____

SPOUSE'S OCCUPATION/EMPLOYER: _____

EMERGENCY CONTACT: _____ PHONE _____

RELATIONSHIP TO YOU: _____

INSURANCE INFORMATION

_____YES, I AM THE INSURED/GUARANTOR

_____ NO, SEE INFORMATION BELOW RELATIONSHIP TO PATIENT _____

NAME _____ DATE OF BIRTH _____ SSN# _____

ADDRESS _____ CITY, STATE, ZIP _____

PRIMARY INSURANCE _____ SECONDARY INSURANCE _____

INSURED _____ INSURED _____

INSURED DATE OF BIRTH _____ INSURED DATE OF BIRTH _____

INSURED SSN: _____ INSURED SSN: _____

INSURANCE ID NUMBER _____ INSURANCE ID NUMBER _____

GROUP NUMBER _____ GROUP NUMBER _____

AUTHORIZATION AND CONSENT

I, THE UNDERSIGNED, ACKNOWLEDGE THAT I AM FINANCIALLY RESPONSIBLE FOR ALL BILLS INCURRED WHILE RECEIVING SERVICES FROM WOMEN'S CARE CONSULTANTS, LLC. I FURTHER AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS INSURANCE CLAIMS. I FURTHER AUTHORIZE THE ACCESS OF HISTORICAL PRESCRIPTION DRUG INFORMATION FROM OUTSIDE SOURCES. A PHOTOCOPY OF THIS ASSIGNMENT IS TO BE CONSIDERED AS VALID AS THE ORIGINAL.
I ALSO GRANT MY HEALTHCARE PROVIDER PERMISSION TO CONTACT ME VIA AN AUTOMATED PHONE/TEXT/EMAIL SYSTEM. I AUTHORIZE MY HEALTHCARE PROVIDER TO DISCLOSE TO THIRD PARTIES WHO ANSWER MY PHONE OR HAVE ACCESS TO MY COMMUNICATIONS MY LIMITED PROTECTED HEALTH INFORMATION, AND TO LEAVE A MESSAGE ON THESE DEVICES.

PATIENT SIGNATURE **DATE**

Women's Care Consultants
Financial Policy

Patients are responsible for payment for medical care they receive from WCC. WCC developed this financial policy to inform patients about their financial obligations under various laws, insurance company rules, etc. Please read this carefully and if you have any questions, do not hesitate to ask our office staff. Office staff are not authorized to make exceptions to this policy.

1. Most major insurance plans, including Medicare, have contracts with WCC. Proof of insurance coverage is required at the time of service. If you are **not covered by a plan we accept or do not have an up-to-date insurance card, payment in full** is expected at the time of service.

2. Your insurance benefits are a contract between you and your insurance company. While we may assist you, knowing your insurance plan's coverage and rules is your responsibility.

3. Co-payments, deductibles, convenience charges, or other amounts not paid by insurance must be paid at the time of service. WCC accepts MasterCard, Visa, Discover, American Express, checks, and most debit cards. While accepted, we prefer <u>not</u> to take cash. WCC will obtain your preferred payment method for your file. By choosing to use WCC's services, you agree that amounts not covered by insurance or that the insurance plan identifies as the "patient's responsibility" will be collected automatically using the payment you provided.

4. WCC refers balance past due over **90 days to an outside agency** for collection of the unpaid balance and the cost of collection.

_____	_____	_____
Patient Signature	Patient Printed Name	Date

Women's Care Consultants

Credit/Debit/HSA card on File Policy

To our patients:

Recent changes in the healthcare markets and payment processes have insurance altered coverages to shift more of the cost of care to the patients. Many policies have large deductibles and/or copayments that won't be known until after your services are submitted to your insurance carrier.

These external factors make it necessary for Women's Care Consultants to maintain a credit card or debit card on file for each patient. The card is stored in your patient medical record- the same HIPAA compliant software that protects your other confidential medical information.

Once your insurance company notifies us how much of the bill is considered your responsibility, we will send three monthly statements. If we do not receive a response or payment during the time of that billing period, we will automatically charge your credit/debit card and provide you with a confirmation of the charge. If the balance is over $200, we will charge the card in the amount of $200 each month until the balance is paid. You may call to revise the payment plan if necessary.

If you have any questions, please do not hesitate to ask.

I agree that Women's Care Consultants may charge the card below for the charges that are determined to be patient's responsibility by my insurance company.

Please circle one of the following:

Visa MasterCard Discover

Name as it appears on the card _____

Card Number _____ _____ _____ _____

Expiration Date _____

CVV No. _____

Cardholder signature _____

Women's Care consultants

Sarah E. Cusworth, M.D.
Jennifer A. Meyer, M.D.
Timothy C. Philpott, M.D.
Angela M. Reining, M.D.
Terri L. Sippel, W.H.N.P.
Marla R. Smith, W.H.N.P.

Authorization of Release of Information

to Family and/or friends

Name of Patient: _____ Date of Birth_____

I authorize Women's Care Consultants to release protected health information to the entities named below:

Give information to spouse or partner: YES NO N/A

Name of spouse or partner: _____

Give information to a family member or friend, please list:

NAME	RELATIONSHIP	PHONE NUMBER

Please list any restrictions regarding information to be released: _____

_____

Rights of Patient: I understand that I have the right to revoke this authorization at any time and I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to Women's Care Consultants. I understand that a revocation is not effective in cases where the information has already been disclosed, but will be effective immediately upon receipt of notification by this practice. I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal state law. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditional on signing this authorization. This authorization shall be in force and effect until revoked by the patient or representatives signing the authorization:

_____

Signature of Patient or Legal Guardian Date

3023 N. Ballas Road, Suite 120 D, St. Louis, MO 63131
phone: 314-432-3669 | fax: 314-432-3118 | exchange: 314-991-3900
wcc-obgyn.com

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Consent for Preventative Care Services

Your Insurance Company defines a "Well-Woman Exam" as a yearly exam without **any** complaints or problems. Our physicians and nurse

practitioners at Women's Care Consultant's, LLC, bill out for the services that are provided, not solely for the reason why the appointment was scheduled.

Additional medical services during that appointment beyond the Well-Woman Exam for any issues you would like to discuss during your Well-Woman Exam will likely generate additional charges. Because the benefit structure of each insurance company is different, please let us know how you want the medical professionals at Women's Care Consultant's to handle your care.

Please select one option below:

_____ I choose to only have preventative services performed today, and I will schedule a follow up appointment for any problems and/or complaints that I may have (**Well-Woman Exam only**).

_____ I would like to discuss other concerns and/or complaints and I will schedule my Well-Woman Exam for another day (**Problem office visit only**).

_____ I wish to proceed with my Well-Woman Exam and I am aware that my visit will be billed for all the services provided today based on the billing practices of my insurance (**Well-Woman Exam & problem**). (**Each insurance company processes claims differently and may not cover both visits on the same date of service**)

_____ _____

Print Name Date of Birth

_____ _____

Signature Date

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Annual History Form

Women's Care Consultants, LLC

THANK YOU IN ADVANCE!
As you will soon see, we have expanded our history form. We know it is a chore to fill out these forms. A very thorough history allows us to make much better and safer medical decisions for you.

Date:_____ Name:_____

What name should we call you?_____ Date of Birth:_____ Age:_____

Who referred you to us?_____ -->Relationship to you:_____

Occupation:_____ Place of Work:_____

Who is your doctor? PHILPOTT REINING MEYER CUSWORTH

What can we do for you today?
☐ Annual Exam/Well Woman Exam
☐ Help with this problem:
_____
_____
_____

Refills & dose:_____
_____
_____

List All Prescription Medications and Dose(s):
☐ **None (I take NO prescription medications)**
1._____ dose:_____
2._____
3._____
4._____
5._____
6._____

Are you allergic to LATEX?
☐ Yes ☐ No

List all medications you are allergic to
☐ **I have NO known drug allergies**

Drug Name	Reaction (rash, etc.)
_____	_____
_____	_____
_____	_____
_____	_____

Your Personal Medical History: Check all that apply
☐ Diabetes
☐ High Blood Pressure
☐ Heart Disease (type:_____)
☐ Decreased blood clotting ability
☐ Blood clots in the leg veins (DVT) or lungs (PE)
☐ Asthma/COPD
☐ Any other problem(s) you take medication for:
_____

If you are POST-Menopausal:

1. What year was your last period? _____
2. Are you having hot flashes?
☐ Yes # per week:_____ ☐ No Hot Flashes

Any other bothersome menopause symptoms?
_____
_____
_____

If you are PRE-Menopausal:

1. Date of your Last Menstrual Period started_____ ended_____.
2. Do you start every 28 days?
☐ Yes ☐ No, every_____days.
3. On average how many days does your period last?_____days
4. You bleed heavily for_____days.
5. At most, you use_____pads/tampons per day.

Annual History Form

Women's Care Consultants, LLC

Date of your last PAP SMEAR:_____ Was the result normal? ☐ Yes ☐ No

Have you ever had an abnormal Pap Smear? ☐ No ☐ Yes, In what year:_____

Treatment(s): ☐ Repap ☐ Colpo ☐ Cryo ☐ LEEP Other_____

What were the results? _____

Last MAMMOGRAM: *month/year* _____

Have you ever had an abnormal Mammogram? ☐ No ☐ Yes, year_____, result:_____

Do you do self breast exams? ☐ Monthly ☐ Occasionally ☐ Never

Have you had COLONOSCOPY? ☐ No ☐ Yes, year_____, result:_____

Have you had a BONE DENSITY XRAY ("DEXA"): ☐ No ☐ Yes, month/year_____

☐ Normal ☐ Abnormal, started treatment with:_____

Treated for any of the following: ☐ Genital Herpes ☐ PID ☐ Chlamydia ☐ Gonorrhea ☐ Trichomonas ☐ Other STD_____

Are you in a sexual relationship now? ☐ No ☐ Yes, single partner ☐ Yes, more than 1 partner

How are you preventing pregnancy?

- ☐ I'M NOT, we've been trying since_____
- ☐ Abstinence
- ☐ Birth Control Pill, name: _____
- ☐ Condoms
- ☐ Depo Provera, date of last shot _____
- ☐ Diaphragm
- ☐ IUD : ☐ Mirena (5yr) ☐ Paraguard (10yr)
  When was it inserted? mo/yr_____
- ☐ Menopause/Hysterectomy
- ☐ Same Sex Partner
- ☐ Partner has vasectomy
- ☐ Rhythm/Natural
- ☐ Tubal Ligation
- ☐ Other:_____

Total # of pregnancies _____

Deliveries_____ Miscarriage(s)_____

Elective termination(s)_____ Tubal pregnancy _____

Birth Year	Vaginal or C-section?	Child's Name	Gender

Any complications with pregnancy? *Describe:*

_____

_____

_____

VACCINATION HISTORY. Below are the recommended vaccines for all non-pregnant adults. Please indicate if you are current on the following vaccinations:

Current

- ☐ Hepatits A ("food borne")
- ☐ Hepatitis B ("blood borne")
- ☐ HPV (Human papillomavirus), e.g. "Gardasil"
- ☐ MMR (Measles, Mumps, Rubella)
- ☐ Tdap (Tetanus, diphtheria, pertussis "whooping")
- ☐ Varicella (Chicken pox: check if you have had a PRIOR INFECTION with Chicken Pox)

Annual History Form

Women's Care Consultants, LLC

PRIOR GYNECOLOGIC SURGERY

Hysterectomy: Year_____
Reason for hysterectomy:_____
- ☐ Vaginal
- ☐ Abdominal
- ☐ Laparoscopic

Were your ovaries removed? ☐ No
Yes: ☐ Both ☐ Left only ☐ Right only
Year ovaries removed:_____

Other GYN Surgeries:

Year	Surgery
_____	_____
_____	_____
_____	_____

Any Other Surgeries? ☐ No

- ☐ Appendix removed year_____
- ☐ Gallbladder removed year_____
- ☐ Heart-describe type & year:_____
- ☐ Bladder-describe type & year:_____
- ☐ Breast-describe type & year:_____

Other surgeries:

Year	Surgery
_____	_____
_____	_____
_____	_____

Not including surgery or pregnancy, have you ever been hospitalized? ☐ No
☐ Yes, when and what for?_____

Family History: (Example: Maternal Aunt)

	Relationship	Age
☐ Breast cancer	_____	_____
☐ Cervical cancer	_____	_____
☐ Ovarian cancer	_____	_____
☐ Uterine cancer	_____	_____
☐ Colon cancer	_____	_____
☐ Clotting problem	_____	_____
☐ Diabetes	_____	_____
☐ Osteoporosis	_____	_____
☐ Heart Disease	_____	
☐ other:	_____	_____

Are you having any other problems?

- ☐ Breast:_____
- ☐ Head/Throat:_____
- ☐ Digestive:_____
- ☐ Heart/Lung:_____
- ☐ Psychiatric:_____
- ☐ Urinary:_____
- ☐ Neurologic/Muscular:_____
- ☐ Other_____

☐ **None**

Social History:
Husband/Partner's Name:_____ His/Her Occupation: _____
How should we refer to this person (Husband, Fiance, Friend, etc.)?_____
Do you smoke ? ☐ No ☐ Yes, # packs per day _____
Do you drink alcohol? ☐ No ☐ Yes, # of drinks per week _____
Any recreational drug use? ☐ No ☐ Yes, type_____ # times/week _____

Would you prefer that an assistant is in the room when the doctor or nurse practitioner does your exam?

☐ **Yes** ☐ **No** ☐ **Does not matter**

All finished, thank you!