Heartland Women's Group
Gynecology and Obstetric Services

_____ Bruce Bammel, M.D.
_____ Dawne A. Lowden, M.D.
_____ Janna Chibry, M.D.
_____ Katie Sutton, M.D.
_____ Kelli Wehling, APRN
_____ Melissa Hague, M.D.
_____ James R. Whiddon, M.D.

PATIENT INFORMATION

DATE: _____

PATIENT'S NAME: _____
FIRST MIDDLE LAST MAIDEN NAME

CURRENT ADDRESS: _____
STREET APT. # CITY STATE ZIP CODE

BIRTH DATE: _____ AGE_____ RACE_____ SS_____
MONTH DAY YEAR

MARITAL STATUS:_____ HUSBAND'S NAME:_____

HOME PHONE: _____ PATIENT'S OCCUPATION: _____

CELL PHONE:_____ EMAIL ADDRESS:_____

PATIENT'S EMPLOYER: _____
COMPANY NAME PHONE NUMBER

ADDRESS

HUSBAND'S EMPLOYER: _____
COMPANY NAME PHONE NUMBER

ADDRESS

PERSON TO NOTIFY IN CASE OF EMERGENCY:_____
(OTHER THAN SPOUSE)

HOW RELATED:_____ _____
ADDRESS PHONE NUMBER

REFERRING PHYSICIAN:_____ PRIMARY CARE PHYSICIAN:_____

PHARMACY NAME / CITY:_____

PRIMARY INSURANCE CO. _____ _____ _____
NAME OF INSURANCE CO. EMPLOYER EFFECTIVE DATE

(CLAIM MAILING ADDRESS) POLICY HOLDER

IDENTIFICATION NUMBER GROUP NUMBER POLICY HOLDER SS NUMBER

POLICY HOLDER BIRTH DATE:_____ GENDER: Male or Female
MONTH DAY YEAR

SECONDARY INSURANCE CO. _____
NAME OF INSURANCE CO. EMPLOYER

(CLAIM MAILING ADDRESS) POLICY HOLDER

IDENTIFICATION NUMBER GROUP NUMBER POLICY HOLDER SS NUMBER

POLICY HOLDER BIRTH DATE:_____ GENDER: Male or Female
MONTH DAY YEAR

I hereby authorize Heartland Women's Health, PA to release any records/information needed to process medical/surgical health insurance claims. I also authorize payment of medical/surgical benefits for services performed by Heartland Women's Health, PA providers. I understand that regardless of insurance coverage, I am responsible for payment for any services provided by Heartland Women's Health, PA. A copy of this authorization is as valid as the original.

Patient Signature:_____

Heartland Women's Group Patient HIPAA Acknowledgment and Consent Form

Patient Name: _____

Date of Birth: _____

_____ (Patient initials) **Notice of Privacy Practices.** I acknowledge that I have received the practice's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices.

_____ (Patient initials) **Release of Information.** I hereby permit practice and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information regarding a prior admission(s) at other HCA affiliated facilities may be made available to subsequent HCA-affiliated admitting facilities to coordinate Patient care or for case management purposes. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.
- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

Disclosures to Family Members and/or Friends

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

	Name	Relationship	Contact Number
Ex:	John Doe	Spouse	(999)999-9999
1:			
2:			
3:			

Consent to Email or Text Usage for Appointment Reminders and Other Healthcare Communications:

Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information.
If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from the Practice.

_____ (Patient initials) I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing (see revocation section below).
The cell phone number that I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information is_____.
The email that I authorize to receive email messages for appointment reminders and general health reminders/feedback/information is_____.

The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Revocation
I hereby revoke my request for future communications via email and/or text.
__I hereby revoke my request to receive any future appointment reminders, feedback, and general health via text messages.
__ I hereby revoke my request to receive any future appointment reminders, feedback, and general health via email.
NOTE: This revocation only applies to communications from this Practice.
Patient Name: _____

Patient/Patient Representative Signature: _____

Date: _____ *Time:* _____

Consent for Photographing or Other Recording for Security and/or Health Care Operations
❑ Yes ❑ No I consent to photographs, videotapes, digital or audio recordings, and/or images of me being recorded for security purposes and/or the practice's health care operations purposes (e.g., quality improvement activities). I understand that the facility retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used without a specific written authorization from me or my legal representative unless it is for treatment, payment or health care operations purposes or otherwise permitted or required by law.

Patient Signature _____ Date _____

Patient Financial Policy

Thank you for choosing Heartland Women's Group as your health care provider. We are committed to your treatment being successful. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, our policies, or your responsibilities. Carefully review the following information and return the last page of this form with your signature and date.

We request all patients complete our Patient Information Form prior to seeing the physician and annually thereafter. It is your responsibility to notify our office of any patient information changes (i.e., address, name, insurance information, etc).

INSURANCE

It is the patient's responsibility to provide the clinic with current insurance information. We will ask for your insurance card at your first visit to obtain a copy for our records. We may occasionally request a copy at a later date to update your records, so please have your insurance card every time you come to our office. **If current information is not obtained at the time of service, you will be considered self-pay. Full payment for services will be required at that time. If you are unable to pay, the appointment will be rescheduled to a later date.**

Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your claims for you. However, we will not become involved in disputes between you and your insurance carrier. This includes, but is not limited to, deductibles, copayments, non-covered charges and "usual and customary" charges. We will supply information as necessary. **You are ultimately responsible for the timely payment of your account.**

COPAYS

Your copay is due at the time of services rendered.

UNPAID BALANCES

If your insurance has not paid the balance of your claims in full, you will receive a statement notifying you of the amount due. You may call our billing office (888-422-7720) to set up payment arrangements, however, at all subsequent appointments, you will also be asked for payment of any past due balance. After insurance pays, the patient balance must be paid within 60 days or it will be considered for further collection activity.

DISCOUNTS

As a courtesy, the clinic offers a 35% discount to all patients with no insurance coverage ***who pay in full at the time of service.*** This discount is available only on the actual date of services. All billed services will be at the full fee.

RETURNED CHECKS

The charge for a returned check is $25 payable by cash or money order. This will be applied to your account in addition to the insufficient funds amount. You may be placed on a "Cash Only" basis following any returned check.

MINORS

The parent(s) or guardian(s) is responsible for full payment and will receive the billing statements. A signed release to treat may be required for unaccompanied minors.

OB PATIENTS (with insurance)

Our office will pre-certify your pregnancy and complete any necessary paperwork required by your insurance company. We will also obtain your OB benefit coverage, which will include deductible and copay information (for physician charges only). If you are responsible for any deductible and/or copay, these amounts will need to be paid in full before your second trimester. If this is not feasible, payment arrangements can be discussed with our business office. Any other expenses incurred during your pregnancy, by our office, (i.e., injections, procedures, etc) will also need to be paid during your care.

OB PATIENTS (without insurance)

If you do not have insurance, you will be given a separate payment policy. The balance is due in full at the time of your first appointment. A 35% discount will be given. These amounts are physician charges only and do not include any hospital, laboratory, sonograms, or additional services needed during or at the time of your delivery.

FMLA PAPERWORK

There is a fee of $15.00 for completion of FMLA paperwork. Payment is requested at the time of request. We ask that FMLA paperwork be given to the office and **not the physician.**

LAB AND PATHOLOGY

We use WPM Pathology and Quest Diagnostics for all of our lab and pathology services. It is the patient's responsibility to know if your insurance contracts with these facilities. If they do not, then you will need to let the nurse know ***prior*** to the visit. Please be advised that WPM and Quest do their own billing. You will receive a separate statement from them for their services. If you have any questions regarding their charges, please refer to the phone number on ***their*** statement.

SONOGRAMS

For liability reasons, we may send your sonogram to Maternal Fetal Associates for Dr O'Hara to read. ***This means you will receive two bills.*** One from our office for performing the sonogram and a separate bill from Dr O'Hara for reading it.

We accept cash, checks, Visa and Mastercard.

Thank you for understanding our Financial Policy. We appreciate the opportunity to provide our services for your medical needs. Your assistance and cooperation will be most appreciated. Should you have any questions or concerns, please contact us.

I have read and agree with Heartland Women's Group Financial Policy.

_____

Patient Name (Please Print)

_____ _____

Patient/Responsible Party Signature Date

Heartland Women's Group
Gynecology and Obstetric Services

Dawne Lowden, MD
Melissa Hague, MD
James Whiddon, MD
Janna Chibry, MD
Kelli Wehling, ARNP, WHNP-BC

Name: _____ Date: _____
Family Doctor:_____Pharmacy/Location: _____

WELCOME:

Accurate completion of this health history form is greatly appreciated. This will allow us to address your health concerns and make recommendations. Please let us know if you have any questions and thank you for your assistance.

Age_____ Reason for today's visit and any questions for the Physician: _____

_____

_____

Obstetrical History:

Please list the year and outcome (vaginal, c-section, miscarriage, or abortion) of each pregnancy:

Year	Outcome	Sex	Weight	Complications	Hospital

Gynecologic History

1. Menstrual History: Age at onset:_____ Number of days between periods:_____
   Number of days you flow: _____ Date of last period: _____ Concerns about your
   period: _____
2. Age at first intercourse: _____
3. History of venereal disease such as warts, gonorrhea, Chlamydia, herpes, syphilis: _____
   _____
4. History of infection in uterus and/or fallopian tubes: _____
5. History of sexual abuse: _____ or physical abuse: _____
6. Date of last Pap smear: _____ History of abnormal Pap smear: _____

7. Date of last mammogram: _____ Colonoscopy: _____ Bone density: _____

8. Please check if you want a screening test for Chlamydia/Gonorrhea _____AIDS_____

Personal Medical History

Surgical History – please list all surgeries you have had and approximate dates:

a. _____

b. _____

c. _____

d. _____

e. _____

Hospitalizations:

a. _____

b. _____

c. _____

Please list current medications you are taking (including birth control):_____

_____

_____

Please list allergies to medications: _____

_____

Are you allergic to Latex? _____Yes _____No

Have you ever had any unusual childhood illnesses, such as rheumatic fever or seizures? _____

_____

Past Medical History

Have you had any past history of medical problems in the following areas? If so, please describe.

a. Eye or visual problems: _____

b. Ear, nose or throat problems: _____

c. Thyroid disorders or diabetes: _____

d. Lung disease (such as Pneumonia, Bronchitis, Asthma): _____

_____

e. Heart problems or high blood pressure: _____

_____

f. Blood transfusion: _____

g. Liver or Gallbladder disease (such as Hepatitis, Jaundice or Gallstones): _____

_____

h. Stomach disorders (such as Ulcers, Gastritis, Hiatal Hernia): _____

_____

i. Intestinal disorders (such as Colitis, Spastic Colon, Polyps): _____

_____

j. Recurrent Urinary Tract Infections or Incontinence: _____

k. Kidney Disease: _____

l. Anemia or blood clotting disorder: _____

m. Bone or joint disease (such as Arthritis or Osteoporosis): _____

_____

n. Neurological problems (such as Migraines): _____

o. Mental disorders (such as Depression, Anxiety, Attacks, Nervous Breakdown): _____

_____

Family History - please list **any family members** with the following illnesses (Parents, Siblings, Grandparents, Aunts and/or Uncles; mother and father's sides of the family):

a. Cancers (include type of cancer & age at diagnosis): _____

_____

b. Blood Disorders: _____

c. Lupus/Diabetes/Thyroid:_____

d. Birth Defects: _____

e. Heart Disease: _____

Social History

a. Cigarette smoking: Yes / No Amount: _____ Are you interested in quitting? _____

b. Frequency of alcohol use: _____

c. History of any recreational drug use: _____

d. Occupation or type of employment: _____

e. Married _____ Single _____ Name of Significant Other _____

Review of Systems – please **circle** any symptoms that you are presently experiencing:

Constitutional: chills, fatigue, fever, night sweats, weight gain, weight loss
Respiratory: cough, difficulty breathing, recent infection, known TB exposure
Cardiovascular: irregular heart beat, swelling in hands/feet, chest pain, difficulty breathing laying flat
Gastrointestinal: abdominal pain, constipation, diarrhea, heartburn, nausea, vomiting
Genitourinary: pain with urination, frequent urination, blood in urine, urinary incontinence, urgency
Reproductive: painful intercourse, infertility, vaginal itching, vaginal discharge, irregular menstrual cycle, pelvic pain, breast pain, nipple discharge
Metabolic: cold intolerance, hair loss, heat intolerance
Neuro: dizziness, weakness, headache, seizures, visual changes
Musculoskeletal: back pain, muscle/joint pain, swelling in joints
Immunological: seasonal allergies, food allergies: please list _____
Dermatology: acne, history of skin infections, rash
Hematologic: easy bruising, blood disorder
Ear, Nose: hearing loss, ear drainage, nasal drainage

Personal Information

Patient Name: _____ **Date of Birth:** _____ **Age:** _____

Today's Date: _____ **Health Care Provider:** _____

Instructions: This is a screening tool for cancers that run in families. Please mark Y for those that apply to YOU and/or YOUR BIOLOGICAL FAMILY (on both your mother's/maternal or father's/paternal side). Next to each statement, please list the relationship(s) to you and age of diagnosis for each cancer in your family. You and the following close blood family members should be considered:

- First-degree relatives: Mother, father, full siblings, or children
- Second-degree relatives: Grandparents, grandchildren, aunts, uncles, nephews, nieces or half-siblings
- Third degree relatives: First-cousins, great-grandparents or great grandchildren

YOUR FAMILY'S Cancer History (Please be thorough and accurate)

	CANCER	YOU (age)	PARENTS / SIBLINGS / CHILDREN	AGE	MOTHER'S SIDE	AGE	FATHER'S SIDE	AGE
☐ Y ☐ N	*EXAMPLE: BREAST CANCER*		*Sister*	*41*	*Aunt Cousin*	*45 61*	*Grandmother*	*53*
Y N	BREAST CANCER							
Y N	OVARIAN CANCER							
Y N	UTERINE/ENDOMETRIAL CANCER							
Y N	COLON/RECTAL CANCER							
Y N	OTHER CANCER(S) (SPECIFY):							

Y N Are you of Jewish descent?

Y N Have you or anyone in your family had genetic testing for a hereditary cancer syndrome?
If yes, please explain and include a copy of the result:

Testing Criteria (Check all that apply to you or your family)

Hereditary Breast and Ovarian Cancer Syndrome

Breast cancer diagnosed at or under age 45*
Ovarian cancer at any age*
Two primary breast cancers in the same person with one diagnosed at or under age 50*
Two relatives on the same side of the family with breast cancer, one diagnosed at or under age 50
Three relatives on the same side of the family with breast and/or ovarian cancer at any age
Triple negative breast cancer at or under the age of 60 (receptor status negative for ER, PR and HER2)
Male breast cancer
Three or more relatives on the same side of the family with any of the following cancers: breast, ovarian, pancreatic, prostate
Ashkenazi Jewish ancestry with an HBOC-associated cancer**

Lynch Syndrome

A personal history of colon/rectal cancer or endometrial cancer diagnosed at or under age 50
A personal history of two or more Lynch syndrome cancers***
Two or more relatives with a Lynch syndrome cancer***, one before the age of 50
Three or more relatives with a Lynch syndrome cancer*** at any age

A previously identified BRCA1 or BRCA2 mutation, or Lynch syndrome mutation in the family

* In self, first or second degree family members
**HBOC associated cancer includes: *Breast, ovarian, and pancreatic cancer*
***Lynch-associated cancers include: *colon, endometrial, gastric, ovarian, ureter/renal pelvis, biliary tract, small bowel, pancreas, brain and sebaceous adenomas.*

Cancer Risk Assessment Review and Counseling

Patient's Signature: _____ Date: _____

Health Care Provider's Signature: _____ Date: _____

For Office Use Only:

Follow-up appointment scheduled: YES NO Date of Appointment: _____

Patient offered hereditary cancer genetic testing? YES NO ACCEPTED DECLINED