



Women's Primary Care  
Patient Information



PERSONAL INFORMATION:

Name: _____		Name you go by: _____	
Relationship Status: Single / Married / Divorced / Widowed / Separated / In Committed Relationship			
Date of Birth: _____	Age: _____	Social Security #: _____	
Home Address: _____		City: _____	State: _____ Zip: _____
Home Phone: _____	Cell Phone: _____	E-mail: _____	
Occupation: _____		Place of Employment: _____	
Work Phone: _____		Ext: _____	
Spouse/Partner: _____		Phone (Work or Cell) _____	



IN CASE OF EMERGENCY, PLEASE NOTIFY:

Emergency Contact: _____		Relationship to you: _____	
Address [Street, City, State, Zip]: _____			
Home Phone: _____	Work Phone: _____	Cell Phone: _____	



REFERRAL INFORMATION:

How did you hear about us? _____	May we thank them? Yes / No _____
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Pharmacy INFORMATION:

Pharmacy: _____	Phone: _____
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INSURANCE INFORMATION:

Primary Insurance: _____		Co-pay Amount: _____	
Member ID: _____	Group #: _____		
Member Name (If not you): _____	SSN: _____		
Relationship to you: _____	Member's Birthdate: _____		
Secondary Insurance: _____		Co-pay Amount: _____	
Member ID: _____	Group #: _____		



**Agreement for Payment of Services:** We believe that prompt payment for our services is part of the contract that exists between doctor and patient. We will provide you with quality medical services, including after-hours coverage, 24 hours a day, 7 days a week, and you agree to pay us promptly for this care.

I understand that I am responsible for services provided for me, regardless of insurance coverage, and that payment is due at the time services are rendered. I agree to pay any co-payments, co-insurance, or deductible amounts for which I am responsible under my insurance policy at the time of service. I understand that I may be subject to a \$5 billing fee if unable to pay at the time of service. Any balance that remains unpaid for 30 days or longer may be subject to 1.5% interest per month.

I authorize release of medical information necessary to process my claim, if such information is requested by my insurance company.

I understand the appointment cancellation policy and fee schedule set forth by Women's Primary Care.

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



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## Appointment Cancellation Policy

Women's Primary Care understands that, occasionally, you will be unable to attend your scheduled appointment. When this happens, we ask that you kindly notify our office as early as possible, so that we may open your appointment time to patients who may need more immediate care. We request that, when possible, you provide 24 hours notice. Please remember that given advance notice, someone else may benefit from your reserved time slot.

Unfortunately, we have frequently experienced patients missing their appointments without any advance notice to Women's Primary Care. Such occurrences are detrimental to both our business and to our other patients waiting for an appointment.

Ultimately, you are responsible for remembering your scheduled appointment time. We understand how busy and hectic personal schedules can get, and, *time allowing*, we try to help by placing courtesy reminder calls, especially for physicals and other appointment types that are booked in advance . . . . However, unlike many other medical offices you may attend, we are a small practice and do not always have the luxury of extra time, so please be aware that reminder calls are not a service we provide.

The following fee schedule is in effect for appointments that are missed without advance notice:

Missed Appointment for a Scheduled Physical	\$75.00
Missed Appointment for a Scheduled Procedure	\$50.00
Missed Appointment for Laboratory Visits	\$10.00

Help us maintain the standard of quality care that we strive to maintain.

Thanks for your support.

Women's Primary Care reserves the right to dismiss from the practice any patients who frequently miss scheduled appointments.



**FAMILY HISTORY ~**

Are you adopted? Yes  No

Please indicate any family history of the following conditions:

	<u>MOTHER</u> Alive: yes / no Age _____	<u>FATHER</u> Alive: yes / no Age _____	<u>SISTERS</u> Number _____	<u>BROTHERS</u> Number _____
Alcoholism				
Breast Cancer				
Colon Cancer				
Diabetes				
Glaucoma				
Heart Attack				
Heart Problems				
High Cholesterol				
Hypertension				
Mental Illness				
Osteoporosis				
Stroke				
Other:				

**SOCIAL HISTORY ~**

Abuse: never emotional physical sexual wish to discuss has seen / is seeing counselor

Alcohol: never rarely socially \_\_\_ drinks on \_\_\_ days / weeks Problem: yes no

Carbon monoxide detector: yes no

What do you do for fun? \_\_\_\_\_

Gas heat or hot water in home: yes no

Guns in home: yes no

Healthcare Power of Attorney: yes no

Recreational Drug Use: yes no

Live with: \_\_\_\_\_

Living Will: yes no

Married ~ Single ~ Divorced ~ Widowed ~ Separated ~ In committed relationship

Person or persons to confide in and feel safe: yes no

Pets: yes no What kind? \_\_\_\_\_

Wear seatbelts: yes no

Self Breast Exam: yes no

Sexually Active: Now: yes no with men / women / both Ever: yes no with men / women / both

Smoke Detectors in home: yes no

Wear sunscreen: yes no

Smoke: Currently: yes no How much? \_\_\_\_\_

Ever: yes no When quit \_\_\_\_\_ How long did you smoke? \_\_\_\_\_

Do you drink water every day? yes no

# Women's Primary Care

## Consent for Purposes of Treatment, Payment and Health Care Operations

I consent to the use or disclosure of my protected health information (PHI) by Women's Primary Care (WPC) for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations (TPO).

I have the right to review WPC's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes my rights and the duties of WPC with respect to my PHI and is provided at the office and on their web site at <http://womensprimarycare-raleigh.com/forms/wpchipaa.pdf>

WPC reserves the right to revise its Notice of Privacy Practices at any time. I may obtain a revised Notice of Privacy Practices by accessing the WPC web site, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

With my consent, WPC may call my home or other designated location and leave a message in reference to any items that assist the practice in carrying out TPO. Some examples are appointment reminders, insurance items and calls pertaining to my care, including laboratory results.

Please provide the information requested in this section. WPC will contact you based on your specific instructions.

*In order to protect your privacy, we need to know:*

*Best phone number to reach you:* \_\_\_\_\_

*If work, can we leave a message for you to call us back?* \_\_\_\_\_

*If home, can we leave a detailed message on your answering machine/voice mail?* \_\_\_\_\_

*May we speak with a family member regarding your care?* \_\_\_\_\_

*Is there anyone we may not leave a message with or speak to?* \_\_\_\_\_

*If yes, please list:* \_\_\_\_\_

*Is there an email address that you would like us to use to contact you?* \_\_\_\_\_

*If so, please provide:* \_\_\_\_\_

With my consent, WPC may mail to my home any items that assist the practice in carrying out TPO, such as statements or postcards relaying appointment reminders or test results.

I have the right to request a restriction as to how my PHI is used or disclosed to carry out TPO. WPC is not required to agree to the restrictions, however, if it does, it is bound by that agreement.

I have the right to revoke this consent, in writing, at any time, except to the extent WPC has already made disclosures in reliance upon my prior consent. If I do not sign this consent, WPC may decline to provide treatment to me.

By signing this form, I am consenting to WPC's use and disclosure of my PHI to carry out TPO.

\_\_\_\_\_  
Printed Name of Patient

\_\_\_\_\_  
Signature of Patient, Parent or Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Parent or Legal Guardian