MONARCH
WOMEN'S HEALTH & MED SPA

Patient Registration

PATIENT INFORMATION:

NAME: _____

DATE OF BIRTH: _____/_____/_____

SEX: FEMALE OR MALE

ADDRESS: _____

_____

HOME PHONE: ( ) _____-_____

WORK PHONE: ( ) _____-_____

MOBILE PHONE: ( ) _____-_____

CALL: Y/N **TEXT:** Y/N

SS# _____-_____-_____

E-MAIL: _____

LANGUAGE: _____

RACE: _____

Ethnicity: _____

MARITAL STATUS (PLEASE CIRCLE ONE) :

SINGLE MARRIED DIVORCED WIDOWED

PRIMARY INSURANCE NAME:

_____

POLICY NUMBER: _____

GROUP NUMBER: _____

POLICY HOLDER'S NAME:

_____

RELATIONSHIP TO PATIENT:

_____

GUARANTOR'S INFORMATION NAME:

_____

ADDRESS: _____

_____

RELATIONSHIP TO PATIENT: _____

DOB: _____

SS# _____-_____-_____

PHONE: ( ) _____-_____

EMERGENCY CONTACT INFORMATION

NAME: _____

RELATIONSHIP: _____

PHONE: ( ) _____-_____

WHO CAN WE THANK FOR REFERRING YOU TO US?

PHONE BOOK, INTERNET, FACEBOOK, FRIEND/OTHER:

_____

E-mail address to e-mail Insurance Cards or records:

frontdesk@monarchwomenshealth.com

Patient Name: _____

Date of Birth: _____

HEIGHT:_____' _____"

Reason for Visit: _____

Have you been a patient of ours before in the past for any reason? OB Gyn Both

PHARMACY INFORMATION

NAME: _____

ADDRESS: _____

PRIMARY CARE PROVIDER:

_____

OBSTETRIC HISTORY

Total # of pregnancies: _____

# of full-term deliveries (>36 weeks): _____

# of premature deliveries (less than36 weeks): _____

Ectopics: _____

Miscarriage: _____

Terminations:_____

Total living children: _____

GYNECOLOGIC HISTORY

Age of first period: _____

Last menstrual period: _____

Cycles: Every _____days lasting _____ days

Cycles are: ____Regular ____Irregular

Flow is: ____Light ____Moderate ____Heavy ____Painful

Sexual preference:

Heterosexual

Homosexual

Bisexual Birth control method: _____

Any history of sexually transmitted disease: ____Y ____N

Last PAP SMEAR: _____ Any history of abnormal tests? ____Y ____N

Last Mammogram: _____ Any history of abnormal tests? ____Y ____N

Last Bone Scan: _____ Any history of abnormal tests? ____Y ____N

Last Colonoscopy: _____ Any history of abnormal tests? ____Y ____N

MEDICAL HISTORY

Have you ever had any of the following?

High Blood Pressure	Heart Disease/Attack	Stroke	Blood Clots
High Cholesterol	Diabetes	Liver Disease	Bleeding Problems
Asthma	Migraines	Thyroid Disease	Depression/Anxiety
Cancer	Other: _____		

SURGICAL HISTORY

Please list all your surgeries:

_____ Date: _____ _____ Date: _____

_____ Date: _____ _____ Date: _____

_____ Date: _____ _____ Date: _____

_____ Date: _____ _____ Date: _____

Medications

Please list all your medications and over the counter supplements:

_____ _____ _____ _____

_____ _____ _____

Please list all your allergies:

None

_____

SOCIAL HISTORY

Marital status: _____

Occupation: _____ Any abuse, emotional or physical? Y N

Do you exercise?	Y	N	Type & frequency:	_____
Do you drink caffeine?	Y	N	How much?	_____
Do you smoke?	Y	N	How much?	_____
Do you drink alcohol	Y	N	How often?	_____
Do you use drugs?	Y	N	Which ones?	_____

Family History

Has anyone in your family ever had any of the following? Please note who in the family had each condition (including if relative is paternal or maternal)

High Blood Pressure	Heart Disease/Attack	Breast Cancer	Uterine Cancer
High Cholesterol	Diabetes	Colon Cancer	Ovarian Cancer
Blood Clots	Down Syndrome	Cystic Fibrosis	Tay-Sachs Disease

Bleeding Problems Neutral Tube Defect Sickle Cell Disease A/B-Thalessemia

Office Policies

- What is your phone number?
- Emergency Contact Name: Emergency Contact Phone number:
- **New patients** must arrive **30 minutes prior** to your appointment time with completed paperwork, photo ID, insurance card, and medication list. New patients arriving after their appointment time will be rescheduled. The 10-minute grace period does not apply to new patients.
- **Established patients**: we will honor a **10-minute grace period** for scheduled appointments. However, there may be circumstances when it is necessary to reschedule late patients. This will be determined at the time of your visit.
- Unfortunately, we **cannot** allow food or drinks in our lobby due to numerous spills. We appreciate you putting your food/drinks away while you are here for your visit. This applies to patients, children, and guests.
- While we value family support, we ask that you limit the number of guests to 4 (this includes children) when you come to your office visits. This allows for adequate space accommodations within our waiting room and exam rooms.
- For safety concerns, children are **not permitted** in patient rooms during sterile procedures, sonogram visits or visits involving pelvic and/or breast examinations. Children present in these situations may interfere with our staff's ability to give good care. We ask that children accompanying patients to visits be supervised for the duration of the visit.
- We request that patients call **48 hours in advance** to cancel or reschedule your appointment. Failing to contact the office will be considered a "no-show" and may result in your dismissal from our practice.
- We request that you confirm **48 hours prior to appointment** when your reminder call, text, or email is sent. If you fail to do so, your appointment will **automatically be cancelled** the day prior.
- If you have a missed or "no show" appointment on file, you will be **required** to pay a **non-refundable deposit** to schedule future appointments.
- If you miss or "no show" 2 appointments, you will automatically be **discharged** from the clinic. If you miss a single appointment it may put you at risk of being **discharged** from MWH.

_____ I have read and understand the office policies listed above.
(initials)

Financial Policy

Payment for services not covered by your insurance plan and any out of pocket expenses are **due at the time of service.** Self-pay patients are expected to pay in full at the time of the visit (see Self Pay Agreement). Our office collection policy supersedes any other contract language or statements in managed care contracts or other insurance policies. We accept checks, cash, debit cards: Master Card, Visa, Discover, and American Express. Charges may also be made for appointments cancelled without 48-hour notice. **Any surgeries/procedures that are cancelled within 48 business hours of surgery/procedure, or patients that no-show for their pre-op appointment will be subject to a $125 cancelation fee.**

MWH files insurance claims for all members within one of our managed care plans. We do not file claims on insurance plans that we do not participate with or on new insurance that we have not had an opportunity to verify in advanced of your appointment. Patients with insurance should understand that:

- Your insurance is a contract between *you, your employer* and *the insurance company.* We are not a party to that contract.

- We will file your insurance for plans in which we participate, only if we have the necessary information to verify your benefits 48 hours prior to your appointment and you present your actual card upon arrival. **We do not verify insurance benefits on the same day as your appointment, so you will be asked to self-pay or reschedule.**

_____ **You are responsible to provide us with a copy of all insurance coverage you may have.**
(initials)

- Our fees are generally considered to fall within the acceptable range of usual and customary by most companies and therefore, are covered up to the maximum allowable determined by each carrier.
- Not all services are a covered benefit in your contract. Some insurance companies arbitrarily select certain services they will not cover or may set maximum limits. Such services include laboratory charges, sonograms, injections, and in office procedures, etc. You will receive a separate bill for these services as they are the patient's responsibility. Our billing team is happy to answer any questions you have about a bill and can be reached at (903) 675-7376 ext. 204

We must emphasize that as a medical care provider, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. It is understood that temporary financial problems may affect timely payments of your account. If you have any questions regarding the above information, please do not hesitate to ask.

_____ I have read and understand the financial policies and my responsibilities listed above.
(initials)

Notice of Privacy Practices

To our patients: This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 **(HIPAA).**
Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.
We realize that these laws are complicated, by which we must provide you with the following important information: **use and disclosure of your health information in certain special circumstances**
The following circumstances may require us to use or disclose your health information:

1. To the public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

Your right regarding your health information

1. Communications. You can request that our practice communicates with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for you cares, such as family members and friends. We are not required to agree to your request: however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about, including patient medical records and billing records, but not including psychotherapy notes. You must submit a signed and dated request to:
   Monarch Women's Health
   824 SouthPark Circle Athens, TX 75752

4. You may ask us to amend your health information if you believe it is incorrect or incomplete and if the information is kept by or for our practice. To request an amendment, it must be in writing and provide us with a reason that supports your request for amendment and submitted to:
   Monarch Women's Health
   824 SouthPark Circle
   Athens, TX 75752
5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Private Practices. You may ask us to give you a copy of this notice at any time. To obtain a copy of this notice, contact our front desk receptionist.
6. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

Primary Care Provider Phone number

Additional person(s) authorized to receive any personal information

◯ **I consent to leaving voice mail message containing detailed medical information.**

_____ (initial) I *understand I have a right to review the MWH's Notice of Privacy Practices prior to signing this document. The practice's Notice of Privacy Practices has been provided to me. The Notice of Privacy describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the clinic. The Notice of Privacy Practices also describes my right and the practice's duties with respect to my protected health information.*

Consent for Purposes of Treatment and Assignment of Benefits

- I hereby consent and authorize MWH to diagnose and treat me based on their professional, medical opinion. I have the right to revoke this consent, in writing, at any time, except to the extent that the practice has acted in reliance on this consent.
- I understand that medical providers of MWH who will be examining me include physicians and physicians' assistant who are skilled members of the health care team who are educated to work dependently with physicians and under their supervision provide diagnostic and therapeutic patient care. I understand that I may request to be seen by a physician.
- I consent to the use or disclosure of my protected health information by the providers at MWH for diagnosing or providing treatment to me, obtaining payment from insurance companies or to conduct health care operations of the practice.
- I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations at MWH.
- I understand that MWH office charges do not include any lab work. I am responsible for any lab charges, including biopsies, sonograms, pap smears, etc.
- My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical, mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.
- I hereby authorize and assign all payment and/or insurance benefits for medical services and/or surgical procedures to MWH. I understand that I am responsible for all charges not covered by my insurance plan.

I have read and understand the above consents regarding my medical treatment.

Patient's name(printed)_____ DOB: _____/_____/_____

Signature of patient/parent guardian_____ Date: _____/_____/_____