Arizona Maternity & Women's Clinic

Patient Information

Patient Name: (Last, First, Middle)		**Email:	
Street Address:	City:	State:	Zip:
** Home phone: ( ) - **Cell Phone: ( ) -		Patient Marital Status: Ethnicity: []Single []Married []other	
Birthday:	**<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: [] Living Will [] Medical Power of Attorney	
Emergency contact: Name:_____ Telephone number:_____ Address:_____ Relationship to Patient:_____			
**** What is your preferred method of contact to confirm your future appointment, and to receive normal results?** **[]Phone [] Text []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 RESPONSIBILTY

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 contacted 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

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?_____

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:_____

AM WC Arizona Maternity & Women Clinic

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/portalI465/jsp/login.jsp

THANK YOU,

ARIZONA MATERNITY WOMEN'S CLINIC