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 or no When was your last **PAP SMEAR?**_____ History of ABNORMAL PAP SMEARS: yes or no Have you been diagnosed with **HPV?** yes or no
When was your last **MAMMOGRAM?** _____ History of ABNORMAL MAMMOGRAMS: yes or no

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Menstrual History:
When was your **last menstrual period?** _____
Your age at the **first menstrual period?** _____
Are your menstrual periods **regular or irregular?** Reg or Irreg.
How often are your periods? _____
How many days does your period last? _____
Menstrual flow: _____Light _____ Moderate _____Heavy
Do you have **cramps** with your periods? yes or no
If yes, do you need **medication for relief?** yes or 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 or no
Since menopause, any **vaginal bleeding**? yes or no
Do you have **hot flashes?** yes or no **Vaginal dryness?** yes or no

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Sexual History:
How many sexual partners have you had? _____
Are you sexually active at the present time? yes or no
Have you been sexually active with **more than one partner** in the past six months? yes or no Do you usually have **pain with intercourse?** yes or no What do you use for birth control? _____ Have you ever been physically abused? yes or no Sexually abused? yes or 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 Respiratory **Urinary** Cancer []yes Asthma []yes Incontinence []yes Weight gain []yes Emphysema []yes Kidney Stones []yes Weight loss []yes Bronchitis []yes Blood in urine []yes Fatigue []yes Tuberculosis []yes Urgency []yes Valley Fever []yes Infection/ frequent []yes Pneumonia []yes

Eyes **Neurological** Glaucoma []yes **Gastrointestinal** Seizures []yes Diarrhea, frequent []yes Stroke []yes

ENT/Mouth Ulcers []yes Headaches []yes Hearing loss []yes Jaundice/ hepatitis []yes Sinus problems []yes Constipation []yes **Endocrine** Dental problems []yes Diverticulitis []yes Thyroid disease []yes Diabetes []yes

Cardiovascular Gestational Diabetes []yes Hypertension []yes **Breast** Hair loss []yes Heart Attack []yes Tumor/cyst (benign)[]yes Hair growth []yes Heart palpitations []yes Nipple discharge []yes Heart murmur []yes

Psychiatric **Hematological**

Musculoskeletal Depression []yes Bleeding/Bruising []yes Arthritis []yes Postpartum []yes Anemia []yes Osteoporosis []yes Anxiety []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:

FLU Vaccine : Yes/No **Pneumonia Vaccine: Yes/No**

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 (delivered 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 2hrs?

Patient Signature: _____ 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: _____

FINANCIAL RESPONSIBILITY

Arizona Maternity & Women's Clinic accepts cash, Visa, and Mastercard as payment for services provided. **Please remember, it is the patient's 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 contracted 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 from 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 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 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: _____

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:** Physician 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 services 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 of Insurance Benefits: If a 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 paying her bill in full regardless of the patient's 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.
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: _____

Arizona Maternity & Women's Clinic
Effective Date: October 12, 2016

Our HIPAA Notice of Privacy Practices describes the privacy practices of Arizona Maternity & Women's Clinic. We respect our legal obligations to keep health information that identifies you private, and by law, we are obligated to provide you a notice of our privacy practices.

We are required by law to maintain the privacy or your health information, to follow the terms of our Notice that are currently in effect, and if you request, to provide you a copy of our Notice regarding our privacy practices and legal duties in respect of you and the information we collect and maintain regarding your health information. Our Notice also describes your rights regarding your health information and certain obligations that mandate how we use and disclose your health information.

Your Rights: You may:

- ❖ Request to inspect any copy of your records.
- ❖ Request to amend incomplete or inaccurate information in your records.
- ❖ Receive an accounting of certain disclosures of your health information.
- ❖ Ask for additional privacy protections (although your request may be declined).
- ❖ Ask for confidential communications in a particular manner.
- ❖ Receive a paper copy of this Notice.
- ❖ File a complaint without penalty.

Use and Disclosures: We will not use or disclose your information unless you tell us to do so or unless the law allows or requires us to do so. We use and disclose your information:

- ❖ For treatment, payment, and health care operations.
- ❖ Through patient's scheduling, to notify family or a close friend you have entrusted with your care, or for notification after benefits and service.
- ❖ For certain activities when the law requires it, such as public health, reporting of abuse, neglect, or domestic violence, health oversight, lawsuits and disputes, coroner, medical examiner, or funeral director purposes, organ donation, avoidance of a serious threat to health or safety, worker's compensation, and national security.
- ❖ With your authorization.

Changes to this Notice: We reserve the right to change this Notice at any time as allowed by law. Updated Notices will be in our office and paper copies will be available by request.

Complaints: If you believe that we have not properly respected the privacy of your health information, you may file a complaint with our clinic by contacting an Office Manager by calling (623) 547-7205 or by sending a letter to our office address.

_____ Please indicate below if we may discuss your health information, billing and/or scheduling with someone you trust: [] Spouse: _____ [] Yes, Health Inf []Yes, Billing Info [] Yes, Scheduling

[] Parent(s) or Guardian(s): _____ Indicate Relationship: _____ [] Yes,

Health Info [] Yes, Billing Info [] Yes, Scheduling

[]Relative/Friend/Other:_____ Indicate Relationship: _____ []Yes,

Health Info [] Yes, Billing Info [] Yes, Scheduling

Acknowledgment of Receipt of this Notice: As a patient of Arizona Maternity & Women's Clinic, I acknowledge that I have received and seen this notice and understand that I may request a copy of the full HIPAA Notice Privacy Practices for additional information. I understand that Arizona Maternity & Women's Clinic respects their legal obligation to keep health information private unless required by law. My signature below indicates that I agree to these conditions.

Printed Name:_____

Signature of Patient: _____ Date: _____

(Signature of parent/Guardian if patient is a Minor)

Arizona Maternity & Women's Clinic
Patient Information

Patient Name: (Last, First, Middle)		**Email: (PLEASE PRINT)	
Street Address:	City:	State:	Zip:
**Home Phone: ( ) _____ - _____ **Cell Phone: ( )_____ - _____		Patient Marital Status: [ ]S [ ]M [ ]D [ ]W [ ]O Ethnicity:	
Birthday: _____/_____/_____	**Social Security# _____-_____-_____	Patient Employment Status:	
Pharmacy: **Number# ( ) _____- _____		**Pharmacy Address/Cross roads:**	
Patient Employer:		Employer's Phone Number:	
**Primary Care Physician: _____ [ ] Don't have a Primary 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 appointments 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 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.

Signature: _____ Date: _____