Naples Women's Center
1726 Medical Blvd., Suite 101
Naples, FL 34110-1426
Phone: (239) 513-1992
Fax: (239) 513-9022

DATE ________

NAME ________
LAST FIRST MIDDLE

ID# ________ HOSPITAL OF DELIVERY ________

NEWBORN'S PHYSICIAN ________ REFERRED BY ________

FINAL EDD ________

PRIMARY PROVIDER/GROUP ________

BIRTHDATE	AGE	RACE	MARITAL STATUS S M W D SEP	ADDRESS
OCCUPATION ☐ HOMEMAKER ☐ OUTSIDE WORK ☐ STUDENT Type of Work			EDUCATION (LAST GRADE COMPLETED)	ZIP PHONE (H) (O) INSURANCE CARRIER/MEDICAID#
HUSBAND/FATHER OF BABY			PHONE	EMERGENCY CONTACT PHONE

TOTAL PREG	FULLTERM	PREMATURE	AB INDUCED	AB SPONTANEOUS	MULTIPLE BIRTHS	ECTOPICS	LIVING

MENSTRUAL HISTORY

LM ☐ DEFINITE ☐ UNKNOWN ☐ FINAL ☐ APPROXIMATE (MONTH KNOWN) ☐ NORMAL AMOUNT / DURATION

MENES MONTHLY ☐ YES ☐ NO FREQUENCY: Q ____ DAYS MENARCH ________ (AGE ONSET)

PRIOR MENES ________ DATE ONBCPATCONCEPT. ☐ YES ☐ NO hCG+ ____ / ____ / ____

PAST PREGNANCIES (LAST SIX)

DATE MONTH/ YEAR	GA WEEKS	LENGTH OF LABOR	BIRTH WEIGHT	SEX M/F	TYPE DELIVERY	ANES	PLACE OF DELIVERY	PRETERM LABOR YES/NO	COMMENTS/COMPLICATIONS

PAST MEDICAL HISTORY

	ONeg +Pos	DETAIL POSITIVE REMARKS INCLUDE DATE & TREATMENT
1 DIABETES		
2 HYPERTENSION		
3 HEART DISEASE		
4 AUTO IMMUNE DISORDER		
5 KIDNEY DISEASE/UTI		
6 NEUROLOGIC/EPILEPSY		
7 PSYCHIATRIC		
8 HEPATITIS/LIVER DISEASE		
9 VARICOSITIES/PHLEBITIS		
10 THYROID DYSFUNCTION		
11 TRAUMA/DOMESTIC VIOLENCE		
12 HISTORY OF BLOOD TRANSFS		

	AMT/DAY PRE-PREG	AMT/DAY PRE-PREG	#YEARS USE
13 TOBACCO			
14 ALCOHOL			
15 STREET DRUGS			

	ONeg +Pos	DETAIL. POSITIVE REMARKS INCLUDE DATE & TREATMENT
16. D(Rh) SENSITIZED		
17. PULMONARY (TB, ASTHMA)		
18 ALLERGIES (DRUGS)		
19. BREAST		
20. GYN SURGERY		
21. OPERATION/HOSPITALIZATIONS (YEAR & REASON)		
22. ANESTHETIC COMPLICATIONS		
23. HISTORY OF ABNORMAL PAP		
24. UTERINE ANOMALY / DES		
25. INFERTILITY		
26. RELEVANT FAMILY HISTORY		
27. OTHER		

COMMENTS ________

EXPOSURES AFFECTING HEALTH

1 ☐ YES ☐ NO DO YOU SMOKE CIGARETTES? IF FORMER SMOKER, WHEN DID YOU QUIT? ____________

IF YES, HOW MANY PACKS PER DAY? ____________

2 ☐ YES ☐ NO DO YOU DRINK ALCOHOLIC BEVERAGES NOW OR DID YOU BEFORE YOU BECAME PREGNANT?

IF YES, PLEASE INDICATE NUMBER OF DRINKS PER WEEK: ____________

WHAT TYPE OF DRINKS? ____________

3 PLEASE LIST ANY MEDICATIONS TAKEN SINCE YOUR LAST PERIOD, INCLUDING PRESCRIPTIONS, OVER-THE-COUNTER DRUGS, MULTIVITAMINS, OTHER SUPPLEMENTS, AND ANY HERBAL MEDICINES ____________

4 ☐ YES ☐ NO HAVE YOU USED ANY STREET DRUGS SINCE YOUR LAST MENSTRUAL PERIOD (EG. COCAINE, MARIJUANA)?

IF YES, PLEASE INDICATE NUMBER OF USES PER WEEK ____________

WHAT TYPE OF DRUGS? ____________

5 ☐ YES ☐ NO DO YOU HAVE ANY REASON TO BELIEVE YOU MAY HAVE BEEN EXPOSED TO HIV/AIDS (EG. A HISTORY OF BLOOD TRANSFUSION, INTRAVENOUS DRUG USE, MULTIPLE SEXUAL PARTNERS, SEXUAL EXPOSURE TO A GAY OR BISEXUAL MALE, OR SEXUAL EXPOSURE TO AN INTRAVENOUS DRUG USER)?

6 ☐ YES ☐ NO HAVE YOU BEEN EXPOSED TO CHEMICALS (EG. PESTICIDES, LEAD, HAZARDOUS MATERIAL/AGENTS) OR RADIATION (EG. X-RAYS) SINCE YOU BECAME PREGNANT?

IF YES, PLEASE DESCRIBE ____________

7. ☐ YES ☐ NO ARE YOU ON A RESTRICTED DIET?

IF YES, PLEASE DESCRIBE ____________

GYNECOLOGIC HEALTH HISTORY

1 WHEN WAS YOUR LAST PAP TEST? ____________

☐ YES ☐ NO HAVE YOU RECEIVED THE HPV VACCINE?

☐ YES ☐ NO HAVE YOU EVER HAD AN ABNORMAL PAP TEST?

IF YES, WHEN AND HOW WERE YOU TREATED? ____________

WHAT WAS THE DIAGNOSIS? ____________

☐ YES ☐ NO HAVE YOU EVER HAD HPV?

2 ☐ YES ☐ NO HAVE YOU EVER HAD ☐ GONORRHEA ☐ CHLAMYDIA ☐ PELVIC INFLAMMATORY DISEASE

IF YES, WHEN, HOW, AND WHERE WERE YOU TREATED? ____________

3 ☐ YES ☐ NO HAVE YOU EVER HAD HERPES?

IF YES, HOW OFTEN DO YOU HAVE OUTBREAKS? ____________

☐ YES ☐ NO HAVE YOU EVER HAD SYPHILIS?

IF YES, HOW, WHEN, AND WHERE WERE YOU TREATED? ____________

4 ☐ YES ☐ NO HAVE YOU EVER USED AN IUD (INTRAUTERINE DEVICE) FOR CONTRACEPTION?

IF YES, PLEASE INDICATE WHEN: ____________

☐ YES ☐ NO DID YOU HAVE ANY PROBLEM WITH THE IUD?

IF YES, PLEASE DESCRIBE: ____________

5 ☐ YES ☐ NO HAVE YOU BEEN TREATED FOR INFERTILITY?

IF YES, PLEASE DESCRIBE WHEN AND TREATMENT RECEIVED: ____________

6 ☐ YES ☐ NO DO YOU HAVE ANY OTHER CONCERNS RELATED TO YOUR PAST HEALTH HISTORY?

IF YES, PLEASE LIST: ____________

FAMILY HISTORY & GENETIC SCREENING

1 WHAT IS YOUR ETHNICITY? ____________ WHAT IS THE ETHNICITY OF THE BABY'S FATHER? ____________

2. ☐ YES ☐ NO HAVE YOU OR HAS THE BABY'S FATHER HAD A CHILD BORN WITH A BIRTH DEFECT?

IF YES, PLEASE DESCRIBE: ____________

3. ☐ YES ☐ NO DID EITHER YOU OR THE BABY'S FATHER HAVE A BIRTH DEFECT?

IF YES, PLEASE DESCRIBE: ____________

4. PLEASE DESCRIBE ANY SPECIAL NEEDS THAT HAVE OCCURRED IN CHILDREN OF YOUR FAMILY OR THE BABY'S FATHER'S FAMILY (EG, MENTAL RETARDATION, BIRTH DEFECTS, EARLY INFANT DEATH, DEFORMITIES, OR INHERITED DISEASES, SUCH AS HEMOPHILIA, MUSCULAR DYSTROPHY, OR CYSTIC FIBROSIS):

____

____

____

HOW IS THIS CHILD/PERSON RELATED TO YOU? ____________

5 ☐ YES ☐ NO DO YOU OR DOES THE BABY'S FATHER HAVE A HISTORY OF PREGNANCY LOSSES (MISCARRIAGES OR STILLBIRTHS)?

IF YES, HAVE EITHER OF YOU HAD GENETIC COUNSELING? ☐ YES ☐ NO

IF YES, HAVE EITHER OF YOU HAD CHROMOSOMAL TESTING? ☐ YES ☐ NO

WHERE AND WHAT WERE THE RESULTS? ____________

6 SOME GENETIC PROBLEMS OCCUR MORE IN COUPLES WITH CERTAIN RACIAL OR ANCESTRAL BACKGROUNDS. PLEASE CHECK IF YOU ARE, OR THE BABY'S FATHER IS, OF ONE OF THESE BACKGROUNDS

☐ YES ☐ NO EASTERN EUROPEAN JEWISH (ASHKENAZI) ANCESTRY

IF YES, HAVE YOU HAD TAY-SACHS SCREENING TESTS? ☐ YES ☐ NO

IF YES, HAVE YOU HAD A CANAVAN SCREENING TEST? ☐ YES ☐ NO

IF YES, HAVE YOU HAD CYSTIC FIBROSIS SCREENING? ☐ YES ☐ NO

IF YES, HAVE YOU HAD FAMILIAL DYSAUTONOMIA SCREENING? ☐ YES ☐ NO

DATE ____________ RESULT: ____________

☐ YES ☐ NO AFRICAN AMERICAN

IF YES, HAVE YOU HAD SICKLE CELL SCREENING? ☐ YES ☐ NO

DATE: ____________ RESULT: ____________

☐ YES ☐ NO MEDITERRANEAN ANCESTRY OR SOUTHEAST ASIAN ANCESTRY

IF YES, HAVE YOU HAD SCREENING FOR INHERITED FORMS OF ANEMIA SUCH AS THALASSEMIA? ☐ YES ☐ NO

☐ YES ☐ NO FRENCH CANADIAN OR CAJUN ANCESTRY

IF YES, HAVE YOU HAD TAY-SACHS SCREENING TESTS? ☐ YES ☐ NO

7. ☐ YES ☐ NO HAVE YOU HAD CYSTIC FIBROSIS SCREENING?

8. PLEASE LIST ANY OTHER CONCERNS YOU HAVE ABOUT BIRTH DEFECTS OR INHERITED DISORDERS

____

____

____

____

____

____

____

9 ☐ YES ☐ NO DO YOU WANT TO HAVE A DOWN SYNDROME RISK ASSESSMENT?

10. ☐ YES ☐ NO IS THE FATHER 50 YEARS OR OLDER?

PSYCHOSOCIAL SCREENING*
1. ☐ YES ☐ NO DO YOU HAVE ANY PROBLEMS (JOB, TRANSPORTATION, ETC.) THAT PREVENT YOU FROM KEEPING YOUR HEALTH CARE APPOINTMENTS?
2. ☐ YES ☐ NO DO YOU FEEL UNSAFE WHERE YOU LIVE?
3. ☐ YES ☐ NO ARE YOU EXPOSED TO SECOND-HAND SMOKE? ☐ YES ☐ NO IN THE PAST 2 MONTHS, HAVE YOU USED ANY FORM OF TOBACCO?
4. ☐ YES ☐ NO IN THE PAST 2 MONTHS, HAVE YOU USED DRUGS OR ALCOHOL (INCLUDING BEER, WINE, OR MIXED DRINKS)?
5. ☐ YES ☐ NO IN THE PAST YEAR, HAVE YOU BEEN THREATENED, HIT, SLAPPED, OR KICKED BY ANYONE YOU KNOW?
6. ☐ YES ☐ NO HAS ANYONE FORCED YOU TO PERFORM ANY SEXUAL ACT THAT YOU DID NOT WANT TO DO?
7. ON A 1-5 SCALE, HOW DO YOU RATE YOUR CURRENT STRESS LEVEL? LOW 1 2 3 4 5 HIGH
8. HOW MANY TIMES HAVE YOU MOVED IN THE PAST 12 MONTHS? ______________
9. IF YOU COULD CHANGE THE TIMING OF THIS PREGNANCY, WOULD YOU WANT IT ☐ EARLIER ☐ LATER ☐ NOT AT ALL

*Modified and reprinted with permission from Florida's Healthy Start Prenatal Risk Screening Instrument. Florida Department of Health. DH 3134. September 1997.

____

PATIENT SIGNATURE

____

PRINT NAME

____

DATE

Notes

____

____

____

____

____

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____

____

PATIENT NAME	BIRTH DATE: / /	ID NO.:	DATE: / /

GENETIC SCREENING*/TERATOLOGY COUNSELING

INCLUDES PATIENT, BABY'S FATHER, OR ANYONE IN EITHER FAMILY WITH:

	YES	NO		YES	NO
1. THALASSEMIA (ITALIAN, GREEK, MEDITERRANEAN, OR ASIAN BACKGROUND): MCV LESS THAN 80			12. HUNTINGTON CHOREA		
2. NEURAL TUBE DEFECT (MENINGOMYELOCELE, SPINA BIFIDA, OR ANENCEPHALY)			13. MENTAL RETARDATION/AUTISM		
			IF YES, WAS PERSON TESTED FOR FRAGILE X?		
3. CONGENITAL HEART DEFECT			14. OTHER INHERITED GENETIC OR CHROMOSOMAL DISORDER		
4. DOWN SYNDROME			15. MATERNAL METABOLIC DISORDER (EG, TYPE 1 DIABETES, PKU)		
5. TAY-SACHS (ASHKENAZI JEWISH, CAJUN, FRENCH CANADIAN)			16. BIRTH DEFECTS NOT LISTED ABOVE		
6. CANAVAN DISEASE (ASHKENAZI JEWISH)			17. RECURRENT PREGNANCY LOSS OR A STILLBIRTH		
7. FAMILIAL DYSAUTONOMIA (ASHKENAZI JEWISH)			18. MEDICATIONS (INCLUDING SUPPLEMENTS, VITAMINS, HERBS, OR OTC DRUGS)/ILLICIT/RECREATIONAL DRUGS/ALCOHOL SINCE LAST MENSTRUAL PERIOD		
8. SICKLE CELL DISEASE OR TRAIT (AFRICAN AMERICAN)					
9. HEMOPHILIA OR OTHER BLOOD DISORDERS					
10. MUSCULAR DYSTROPHY			IF YES, AGENT(S) AND STRENGTH/DOSAGE		
11. CYSTIC FIBROSIS			19. ANY OTHER		

*If a patient has been screened for a genetic disorder previously, the results should be documented but the test should not be repeated.

COMMENTS/COUNSELING: ____________________

INFECTION HISTORY

	YES	NO	
1. LIVE WITH SOMEONE WITH TB OR EXPOSED TO TB			5. HISTORY OF STIs: GONORRHEA ☐ CHLAMYDIA ☐ HPV ☐ SYPHILIS ☐ PID ☐
2. PATIENT OR PARTNER HAS HISTORY OF GENITAL HERPES			6. HIV INFECTION YES ☐ NO ☐
3. RASH OR VIRAL ILLNESS SINCE LAST MENSTRUAL PERIOD			7. HISTORY OF HEPATITIS
4. PRIOR GBS-INFECTED CHILD			8. OTHER (SEE COMMENTS)

COMMENTS: ____________________

INTERVIEWER'S SIGNATURE: ____________________

IMMUNIZATIONS	YES (MONTH/YEAR) ___/___	NO	IF NO, POSTPARTUM VACCINE INDICATED?	IMMUNIZATIONS	YES (MONTH/YEAR) ___/___	NO	IF NO, POSTPARTUM VACCINE INDICATED?
TDAP or TD				HEPATITIS A (WHEN INDICATED)			
INFLUENZA†				HEPATITIS B (WHEN INDICATED)			
VARICELLA†				MENINGOCOCCAL (WHEN INDICATED)			
MMR†				PNEUMOCOCCAL (WHEN INDICATED)			

†All live vaccines are contraindicated in pregnancy, including the live intranasal influenza, MMR, and varicella vaccines. All women who will be pregnant during influenza season (October through May) should receive inactivated influenza vaccine at any point in gestation. Administer the MMR and varicella vaccines postpartum if needed.

INITIAL PHYSICAL EXAMINATION

DATE ___/___/___ WEIGHT ______ HEIGHT ______ BMI ______ BP ______

1. HEENT	☐ NORMAL	☐ ABNORMAL	12. VULVA	☐ NORMAL	☐ CONDYLOMA	☐ LESIONS
2. TEETH	☐ NORMAL	☐ ABNORMAL	13. VAGINA	☐ NORMAL	☐ INFLAMMATION	☐ DISCHARGE
3. SYMPTOMS SINCE LMP	☐ NORMAL	☐ ABNORMAL	14. CERVIX	☐ NORMAL	☐ INFLAMMATION	☐ LESIONS
4. THYROID	☐ NORMAL	☐ ABNORMAL	15. UTERUS SIZE	______ WEEKS		☐ FIBROIDS
5. BREASTS	☐ NORMAL	☐ ABNORMAL	16. ADNEXA	☐ NORMAL	☐ MASS	
6. LUNGS	☐ NORMAL	☐ ABNORMAL	17. RECTUM	☐ NORMAL	☐ ABNORMAL	
7. HEART	☐ NORMAL	☐ ABNORMAL	18. DIAGONAL CONJUGATE	☐ REACHED	☐ NO	______ CM
8. ABDOMEN	☐ NORMAL	☐ ABNORMAL	19. SPINES	☐ AVERAGE	☐ PROMINENT	☐ BLUNT
9. EXTREMITIES	☐ NORMAL	☐ ABNORMAL	20. SACRUM	☐ CONCAVE	☐ STRAIGHT	☐ ANTERIOR
10. SKIN	☐ NORMAL	☐ ABNORMAL	21. SUBPUBIC ARCH	☐ NORMAL	☐ WIDE	☐ NARROW
11. LYMPH NODES	☐ NORMAL	☐ ABNORMAL	22. GYNECOID PELVIC TYPE	☐ YES	☐ NO	

COMMENTS (Number and explain abnormals): ____________________

EXAM BY: ____________________

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ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

Your surgeon is requesting the services of a Registered Nurse First Assist (RNFA). This is common practice for surgical procedures where an extra pair of skilled hands is necessary to assist the surgeon during your operation. This RNFA is in independent practice and is not employed by your surgeon or hospital. She will file a claim with your Insurance company for her services, which are separate from your surgeon and the hospital.

If you have Medicare or Tricare

Currently, Medicare, Tricare and Care Improvement Plus do not recognize Certified Registered Nurse First Assists and will deny payment of these services as "Not Customary". If this is your insurance, you will be billed directly. This financial obligation will be 20 percent of the surgeon's allowable rate.

If you have insurance coverage other than, or in addition to, Medicare or Tricare

Your insurance will be billed for the services of the CRNFA. If your insurance denies payment, an appeals process will be submitted. If the appeals process continues to deny reimbursement, you will receive a bill and will be responsible for the payment of these services. Your responsibility will be limited to 20 percent of the surgeon's allowable charges.

I agree to be responsible for the payment for services provided by my surgeon's designated Registered Nurse First Assist

______________________	Elena Wilson, RNFA
Surgeon's Name	Surgical Assistant
______________________	______________________
Patient's Name	Date of Surgery
______________________	______________________
Signature of Patient	Date Signed

NAPLES WOMEN'S CENTER

Registration Form

Please provide us with your insurance card and valid ID

Patient Information

Name (Last, First, Middle)		Previous Last Name	
Florida Address		City/State/Zip + 4	
Out-of-State Address		City/State/Zip + 4	
Date-of-Birth		Social Security Number	
Driver's License Number		Email Address	
Home Phone	Work Phone	Cell Phone	

Primary Insurance

Primary Insurance		Relation to Subscriber (self, spouse, child)	
Subscriber's Name		Subscriber's Employer	
Subscriber's Date of Birth	Subscriber SS #	Subscriber's ID #	Group #

Secondary Insurance

Secondary Insurance		Relation to Subscriber (self, spouse, child)	
Subscriber's Name		Subscriber's Employer	
Subscriber's Date of Birth	Subscriber SS #	Subscriber's ID #	Group #

Emergency Contact

Name	Relationship	Phone

Referral Information

How did you hear about us? ☐ Doctor Referral ☐ Internet ☐ Telephone Directory ☐ Patient ☐ Television
☐ Other ______________________________

Lab Results

My preferred Pharmacy to use is: _______________ Location: ____________________ Phone: ____________________
My preferred Lab to use is: ____________________ Location: ____________________ Phone: ______________________
How would you like to be contacted regarding your lab results? ☐ Home Phone ☐ Cell Phone ☐ E-mail
Is it okay to leave a detailed message with test results? ☐ Yes ☐ No

Appointments Confirmations

We send annual and scheduled appointment reminders via phone, text and/or email which you must opt in to receive. It is extremely important to confirm the appointment upon receipt of the phone, email or text to ensure that we know you are planning to attend your appointment. *How would you like to be contacted about your appointment?* ☐ Text ☐ Phone ☐ E-mail

Updated 04/11/2017

NAPLES WOMEN'S CENTER

Health

HIPAA PRIVACY ACKNOWLEDGEMENT

I acknowledge that Naples Women's Center has given me an opportunity to review the "Notice of Privacy Practices" in compliance with current HIPAA regulations which are posted in the reception area. If I would like a copy of the HIPAA notice, I will ask for one.

Person signing this form must be 18 years or older. Proof of guardianship may be requested by staff.

______________________________ ______________________________

Patient, Parent or Guardian Name (Print) Patient, Parent or Guardian Signature

The following persons may be contacted in my place regarding appointments, billing, or medical care.

______________________________ ______________________________

Personal Representative (Print) Personal Representative Signature

______________________________ ________________

Relationship Date

ASSIGNMENT OF BENEFITS & RELEASE OF INFORMATION

I hereby request that payment of insurance benefits be made directly to Naples Women's Center on my behalf. I acknowledge and understand that I am financially responsible for all charges relating to the service(s) rendered to my dependent or myself. If, for any reason, my insurance carrier does not pay any portion of my bill, I agree to pay my portion promptly.

I also authorize Naples Women's Center to release any information acquired in the course of my examination or treatment to the insurance company or any other party involved in reimbursement for the claim.

Person signing this form must be 18 years or older. Proof of guardianship may be requested by staff.

______________________________ ________________

Patient, Parent or Guardian Signature Date

FOR MEDICARE PATIENTS ONLY

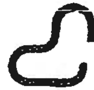
LIFETIME ASSIGNMENT OF MEDICARE BENEFITS

I request that payment of authorized Medicare/Medigap benefits be made to me or on my behalf to Naples Women's Center for any services furnished to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration (HCFA), its agents, and my Medigap insurer, any information needed to determine these benefits or the benefits payable for related services.

This assignment shall serve as a lifetime assignment, unless otherwise requested by me.

______________________________ ________________

Signature of Patient or Personal Representative Date



NAPLES WOMEN'S CENTER

Health

FINANCIAL AGREEMENT

Thankyou for choosing Naples Women's Center. We believe that good medical care starts with good communication. We have created this policy to help our patients understand their responsibilities with respect to our fees.

Patient Information and Insurance
At each visit, you will be asked to verify your personal information, present a copy of your insurance card(s) and a picture ID, pay any outstanding balance and co-payment or charges due for that day's visit. In order for us to verify your insurance, we will ask you to update your insurance/demographic information annually, or more frequently if there has been a change in your coverage. Failure to notify us of a change in your coverage could lead to a denial of claims and patient responsibility of denied charges.

Co-Payments and Deductibles
Payment of co-pays are due at the time of service. We are required to collect co-pays per your contract with your insurance company. We accept cash, check and credit card

Medical insurance may not cover the full cost of medical care. Certain costs, such as deductibles, co-payments and co-insurance, will be passed along to you by your insurance carrier and outlined in an Explanation of Benefits (EOB) that will be mailed by your carrier to you and this office. You are responsible for all amounts your carrier determines to be "Patient Responsibility".

Preventive vs. Medical Coverage
If you are here for a routine preventive exam/ annual well visit, this visit will be submitted as such to your insurance company. If during the course of your preventive visit the doctor addresses with you a problem (i.e., hypertension, pain, etc....) you may also receive a separate medical visit. Some insurance companies require separate copays, deductibles, or coinsurance for these different visits.

Surgical Services and Office Procedures
Surgery and obstetric deductibles may be pre-collected prior to procedure and delivery. The surgical fee includes the procedure performed by your physician and post-operative care for the procedure. Your financial portion is due in full before the surgery. The billing staff will contact you directly and speak with you regarding your scheduling and financial information.

Laboratory & Pathology Services
If your visit includes lab tests, biopsies, pap smears, cultures, etc. you will receive a separate bill from the lab.

Missed Appointments & Returned Check Fees
When an appointment is scheduled, that time is reserved for you and when it is missed or cancelled on short notice, that time cannot be used to see another patient. We require a 24-hour notification if you are unable to keep your appointment. There will be a twenty-five-dollar ($25) charge for any missed appointments. There is also a thirty-five-dollar ($35) fee for any returned check.

Overpayments and/or Refunds

If your Insurance company pays more than what is estimated, you will receive a refund check from our practice if your credit amount is over $200. Please note that refunds will not be issued until after all your claims submitted for your services have been paid. Credit amounts under $200 will remain on your account for future services at our practice unless requested by the patient. Medicare and Medicaid patients will receive any overpayment and /or refund regardless of the amount. Refunds can take up to 12 weeks to process.

NAPLES WOMEN'S CENTER

Health

Collections

Payment is due upon receipt of a statement. Once a patient account is over 90 days old, with no payment activity or attempts to contact the Billing Department to make payment arrangements, the account will be turned over to a Collection Agency. If you are having a financial problem, the most important thing you can do is contact our Billing Department to make payment arrangements. We provide reasonable payment plans designed to collect balances within a year.

We will do our best to help you with your insurance questions. Our Billing Department is available from 8:30AM to 5:00PM Monday through Friday at (239) 513-1992. You can also visit our Web site at www.napleswomenscenter.com and select **Online Portal** to make a payment.

Person signing this form must be 18 years or older. Proof of guardianship may be requested by staff.

____
Signature of Patient, Parent or Guardian

____
Date

Current Pharmacy: Name: ________________ Location:____________________ Phone:____________

Preferred Lab: Name: ________________ Location:____________________ Phone:____________

Date of last Pap Smear? ______________ ☐ Normal ☐ Abnormal

If pap was abnormal, were any of the following performed: ☐ Colposcopy ☐ Cryosurgery ☐ LEEP/Laser/Conization

Date of last Mammogram? ______________ ☐ Normal ☐ Abnormal ☐ Never had a Mammogram

Date of last Bone Density? ______________ ☐ Normal ☐ Osteopenia ☐ Osteoporosis ☐ Never had a Bone Den

Date of last Colonoscopy? ______________ ☐ Never had a Colonoscopy

Family History:

Father's side: (including siblings, uncles/aunts, and grandparents)

☐ Breast Cancer ☐ Depression ☐ Heart Disease ☐ Ovarian Cancer ☐ Uterine Cancer
☐ Colon Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Thyroid Disorder ☐ Blood Clots
☐ Other ____

Mother's side: (including siblings, uncles/aunts, and grandparents)

☐ Breast Cancer ☐ Depression ☐ Heart Disease ☐ Ovarian Cancer ☐ Uterine Cancer
☐ Colon Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Thyroid Disorder ☐ Blood Clots
☐ Other ____

Social History:

Exercise	☐ Yes	☐ No	Type(s) and frequency________________________
Alcohol use	☐ Yes	☐ No	If yes, ________ drink(s) per day/week/month
Tobacco use	☐ Yes	☐ No	If yes, ________ pack(s) per day for __________ year(s)
Caffeine	☐ Yes	☐ No	If yes, ________ caffeinated drinks (coffee, tea, soda) per day/week/mo
Recreational Drug use	☐ Yes	☐ No	Type(s) and frequency________________________

Emotional Abuse	☐ Yes	☐ No	If yes, are you safe now ☐ Yes ☐ No	Counseling ☐ Yes	☐ No
Physical Abuse	☐ Yes	☐ No	If yes, are you safe now ☐ Yes ☐ No	Counseling ☐ Yes	☐ No
Sexual Abuse	☐ Yes	☐ No	If yes, are you safe now ☐ Yes ☐ No	Counseling ☐ Yes	☐ No

Review of Systems - Do you have any of the following symptoms TODAY?

GENERAL:

☐ Yes	☐ No	Hemorrhoids
☐ Yes	☐ No	Recent weight gain/loss of 25 lbs.
☐ Yes	☐ No	Fever
☐ Yes	☐ No	Vision problems (excluding glasses)
☐ Yes	☐ No	Sinus problems
☐ Yes	☐ No	Hearing loss
☐ Yes	☐ No	Chest Pain
☐ Yes	☐ No	Varicose Veins
☐ Yes	☐ No	Shortness of breath
☐ Yes	☐ No	Chronic Cough
☐ Yes	☐ No	Diarrhea
☐ Yes	☐ No	Constipation
☐ Yes	☐ No	Blood in stools
☐ Yes	☐ No	Heartburn/reflux

GYNECOLOGY:

☐ Yes	☐ No	Abnormal Frequent urination
☐ Yes	☐ No	Burning w/ urination
☐ Yes	☐ No	Incontinence
☐ Yes	☐ No	Abnormal Urinary Urgency
☐ Yes	☐ No	Bladder infection
☐ Yes	☐ No	Abdominal pain
☐ Yes	☐ No	Abnormal vaginal discharge
☐ Yes	☐ No	Irregular vaginal bleeding
☐ Yes	☐ No	Pelvic pain
☐ Yes	☐ No	Painful intercourse
☐ Yes	☐ No	Breast lumps
☐ Yes	☐ No	Breast pain
☐ yes	☐ No	Back pain
☐ Yes	☐ No	Depression/anxiety

(**PLEASE NOTE**: Extra charges may/will occur if both a Well Woman exam and Problem visit are discussed on the same da

____ ______________________
Patient Signature Date

____ ______________________
Clinician Signature Date

NAPLES WOMEN'S CENTER: NEW PATIENT MEDICAL HISTORY FORM

Name:________________________ Date of Birth:______________ Age: _____ Today's Date:________________

How did you hear about our office? Please circle: Friend/Family Online Primary Doctor Other __________

Reason for your visit today: Well Woman Exam or Problem visit: ________________________________

WOULD YOU ACCEPT A BLOOD TRANSFUSION IN A LIFE OR DEATH SITUATION? (required): ☐ Yes ☐ No

Medical History: Have you had any of the following?

- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma/COPD
- ☐ Bladder Infections
- ☐ Blood Clots in Lungs/Legs
- ☐ Blood Transfusion
- ☐ Cancer ____________
- ☐ Chickenpox
- ☐ Depression/Anxiety
- ☐ Diabetes
- ☐ Epilepsy/ Seizures
- ☐ Gall Bladder Disease
- ☐ Heart Disease/ Attack
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Disease/Stones
- ☐ Liver Disease/Hepatitis ___
- ☐ Migraines
- ☐ Pelvic Infections
- ☐ Reflux/Heartburn/Ul
- ☐ Stroke
- ☐ Thyroid Disorder
- ☐ Tuberculosis
- ☐ Other: __________

List ALL medications you are currently taking, including over-the-counter medications, vitamins, and herbal remedi

________________ ________________ ________________ ________________
________________ ________________ ________________ ________________

List any allergies to medications: ____ ☐ No Known Allergi

Surgical History - List all surgeries with dates:

________________________________ ________________________________
________________________________ ________________________________

Obstetrical History

☐ Check here if you have NEVER been pregnant.

Number of pregnancies ______ Number of elective abortions ______ Number of ectopic pregnancies ______
Number of living children ______ Number of miscarriages ______ Number of stillbirths ______

Gyn History:

Age of first period __________ If in Menopause, what age/year _________ HPV/Gardasil Vaccine: ☐ Yes ☐ No

Date of last period _________

Cycle Length: every _______ days
lasting _______ days

Periods are: ☐ Regular ☐ Irregular ☐ Painful

Flow is: ☐ Light ☐ Moderate ☐ Heavy ☐ Very Heavy

Are you sexually active ☐ Yes ☐ No ☐ Never **Lifetime Partners:** ☐ Less than 5 ☐ More than 5

Sexual Preference: ☐ Heterosexual ☐ Homosexual ☐ Bisexual ☐ Other ______________

Method of Birth Cont

- ☐ Condoms
- ☐ Natural Family Planning
- ☐ Pills: __________
- ☐ Vasectomy (Partner)
- ☐ Depo Provera
- ☐ IUD: Brand __________ Year inserted ____
- ☐ Tubal/ Essure
- ☐ Vaginal Ring
- ☐ Cervical Cap
- ☐ Sponge
- ☐ Spermicide
- ☐ Withdrawal
- ☐ Hysterectomy
- ☐ None

Have you ever had any of the following STDs?

- ☐ Chlamydia
- ☐ Hepatitis B
- ☐ Herpes
- ☐ HPV
- ☐ Trichomonas
- ☐ Gonorrhea
- ☐ Hepatitis C
- ☐ HIV
- ☐ Syphilis
- ☐ None

NAPLES WOMEN'S CENTER

Health

I have been furnished information in the form of a Brochure prepared by the Florida Birth-Related Neurological Injury Compensation Association (NICA), pursuant to the Section 766.316, Florida Statues, by Naples Women's Center and have been advised that all physicians in the Physicians group are participating physician (s) in that program, wherein certain limited compensation is available in the event certain types of qualifying neurological injuries, may occur during labor, delivery or resuscitation in a hospital.

For specifics on the program, I understand I can contact the Florida Birth-Related Neurological Injury Compensation Association, Post Office Box 14567, Tallahassee, Florida 32317-4567. (800) 398-2129.

I specifically acknowledge that I have received a copy of the Brochure prepared by NICA.

DATED this __________ day of ______________________,20_____,

____
Signature of Patient

____
Printed Name of Patient
Social Security No.: ________________

Attest:

____
Nurse or Physician

Date: ________________________

Note: This Suggested Form is to be utilized only upon the advice of the Physician's Group's counsel. This form is not a required NICA form.