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

NAPLES WOMEN'S CENTER
A HealthLynked Company

Updated 06/21/2017

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

FINANCIAL AGREEMENT

Thank you 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.

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

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/Ulcer
☐ Stroke
☐ Thyroid Disorder
☐ Tuberculosis
☐ Other: ____________

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

____________________ ____________________ ____________________ ____________________

____________________ ____________________ ____________________ ____________________

List any allergies to medications: ____ ☐ No Known Allergies

Current Pharmacy: ________________________ **Location:** ______________________________________

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 _______

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 **New partners since last visit** ☐ Yes ☐ No

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

Method of Birth Control

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

Have you ever had any of the following STDs?

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

Name:______________________________________ Date of Birth:_____________________

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 Density

Date of last Colonoscopy? ______________ ☐ Never had a Colonoscopy

Family History:

Father's side:

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

Mother's side:

☐ 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/month
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	Generally healthy
☐ 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 day)

____ ____________________________

Patient Signature Date

NAPLES WOMEN'S CENTER
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PELVIC/RECTAL EXAMINATION CONSENT

Patient Name: ________________________________ DOB: ______________

I understand that my medical care may require a pelvic (and/or) rectal examination defined as a series of tasks that comprise an examination of the vagina, cervix, uterus, fallopian tubes, ovaries, rectum, or external pelvic tissue or organs using any combination of modalities, which may include, but need not be limited to, the health care provider's gloved hand or instrumentation.

By my signature below, I give my express consent to any and all medically appropriate pelvis/rectal examinations as defined above to be conducted now or in the future by a healthcare provider, medical student, or student receiving training as a healthcare provider that is employed by or contracted by:

NAPLES WOMEN'S CENTER

1265 Creekside Pkwy, Suite 200

Naples, FL 34108

Patient Signature: ______________________ Date: _______ Time: ______

Witness Signature: __________________________________ Date: _______

This office is compliant with and regulated by the Board of Medicine Rule Chapter 64B8 and 64B15, Florida Administrative Code.

Form Date: 6/26/20