PETERSON
WOMEN'S ASSOCIATES

2014

575 Hill Country Dr. Ste 202 Kerrville, TX 78028·(830)258-6237 Office· (830)315-1366 Fax

Patient Name (last, first, MI)	Date of Birth	Social Security Number
Mailing Address	Home Telephone	Work Telephone
City State Zip Code	Cell Phone	Marital Status
Primary Care Physician	Driver's License Number	
Patient's Employer	Email Address	
Patient's Race	Patient's Ethnicity	
Emergency Contact: Name & Number	Relationship of Contact to You:	

Spouse's Name	Work Telephone
Spouse's Employer	
Spouse's SS#	Spouse's Date of Birth

INSURANCE INFORMATION

Medicare Number		Medicaid Number	
Primary Health Plan		Secondary Health Plan	
Group#	ID#	Group#	ID#
Name of Policy Holder (last, first, MI)		Name of Policy Holder (last, first, MI)	
Policy Holder Address		Policy Holder Address	
Telephone Number	Date of Birth	Telephone Number	Date of Birth
Social Security#		Social Security#	

Preferred Pharmacy:

_____ _____

Signature of Patient or Responsible Party **Date**

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Name:_____ **Date of Birth:**_____ **Today's Date:**_____

Reason for visit:_____

Menstrual History:

1st day of last period:_____ # of days bleeding:_____ # of days between periods:_____

Are your periods: Regular Irregular Type of flow: Heavy Medium Light

Are you or do you think you could be pregnant?: YES/NO

Gynecological History:

Have you ever had a Pap Smear?: YES/NO When:_____ Result:_____

Are you post menopausal?: YES/NO Do you have your ovaries?: YES/NO

Have you had a hysterectomy?: YES/NO When:_____ Type:_____

Sexual History:

Are you sexually active?: YES/NO Do you take Birth Control?: YES/NO Type:_____

Have you ever had an STD?: YES/NO When:_____ Type:_____

Would you like to be tested for STD's today?: YES/NO

Reproductive History:

of pregnancies:_____ # of children:_____

# of abortions: _____ # of miscarriages: _____

1. Date of delivery:_____ Weeks Gestation:_____ M/F Weight:_____VAG/C-SECTION

Anesthesia type:_____Complications?: YES/NO If yes, please explain:_____

2. Date of delivery:_____ Weeks Gestation:_____ M/F Weight_____VAG/C-SECTION

Anesthesia type:_____Complications?: YES/NO If yes, please explain:_____

3. Date of delivery:_____ Weeks Gestation:_____ M/F Weight_____VAG/C-SECTION

Anesthesia type:_____Complications?: YES/NO If yes, please explain:_____

Surgical History: (please include dates)

_____

_____

_____

_____

Personal Medical History:

□ High Blood Pressure	□ Diabetes	□ Anemia
□ Heart Disease	□ High Cholesterol	□ Ovarian Cyst
□ Stroke	□ Kidney Disease	□ Endometriosis
□ Liver Disease	□ Depression	□ PCOS
□ Bleeding/ Clotting Disorder	□ COPD	□ Painful/ Irregular periods
□ Asthma	□Thyroid Disease	□Migraines
□Cancer (type) _____	□Other:_____	

Family Medical History: (please indicate which family member ie: mother, father, maternal or paternal grandparent, sibling.)

□ High Blood Pressure_____ □ Diabetes_____ □ Anemia_____
□ Heart Disease_____ □ High Cholesterol_____ □ Ovarian Cyst_____
□ Stroke_____ □ Kidney Disease_____ □ Endometriosis_____
□ Liver Disease_____ □ Depression_____ □ PCOS_____
□ Bleeding/Clotting Disorder_____ □ COPD_____ □ Painful periods_____
□ Asthma_____ □Thyroid Disease_____ □Migraines_____
□Cancer (type) _____ □Other:_____

Social History:

Do you drink alcohol?: YES/NO How often?: _____
Do you smoke?: YES/NO How often?: _____
Do you drink caffeine?: YES/NO If yes, how often?: _____
Do you exercise?: YES/NO If yes, how often?: _____
Any past/present drug use?: YES/NO If yes, what, how often?:_____

Preventive Health:

Have you had a Bone scan?: YES/NO When:_____ Result:_____
Have you had a Colonoscopy?: YES/NO When:_____ Result:_____
Have you had a Mammogram?: YES/NO When:_____ Result: _____
Have you had lab work recently?: YES/NO When:_____ Result:_____
Do you have a Primary Care Physician?: YES/NO Who: _____

Are you allergic to any medications?: YES/NO Please list: _____

Current Medications: (include all prescriptions **and** over the counter medication.)

Medication: _____ Dose: _____ How often:_____
Medication: _____ Dose:_____ How often:_____
Medication: _____ Dose: _____ How often:_____
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Medication: _____ Dose: _____ How often:_____
Medication: _____ Dose: _____ How often:_____
Medication: _____ Dose: _____ How often:_____
Medication: _____ Dose: _____ How often:_____

Please list additional info you would like us to know:

_____
_____
_____
_____
_____
_____

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PATIENT NOTICE OF BILLING PRACTICES

Peterson Women's Associates is committed to providing quality medical services to our patients and clearly defining our financial policy. If you have any questions please ask one of our staff members to assist you.

Payment Due At Time of Service: Medical services provided to you are payable at the time of service. We accept cash, check, debit cards and most major credit cards.
_____ (initial) I understand that I am responsible for payment of co-pays, deductibles and co-insurance at the time service is provided.
_____ (initial) I understand past due amounts must be paid in full prior to the scheduling of any future appointments, unless prior arrangements have been made and approved by management.

Self Pay Patients: Payment is due in full at the time of service. We offer a private pay discount of 20%.

Insurance Billing: Our office bills most major insurances. Any services provided that are not covered by your insurance will become your responsibility. Any services provided that are applied towards your deductible will also become your responsibility. You will receive a statement by mail for these charges. Should you have any questions regarding a statement you received please contact our billing office.

Medicaid Billing: We currently accept the following Medicaid plans: Traditional Medicaid, Women's Health Plan, Molina Health Care, Superior CHIP Perinate and Superior. Your Medicaid must be active at the time of service. We do not accept Retro-Medicaid, or back bill for any services provided prior to you becoming eligible for Medicaid.

Medicare Billing: We currently accept Medicare patients. Medicare deductibles and co-insurance are due in full at the time of service. Any services provided that are not covered by Medicare will become patient responsibility and you will receive a statement by mail.

Patient Credits: Patient credits will be refunded once all visits have been responded to by insurance. No refunds will be issued while there are future appointments scheduled.

Collections: Our preference is to ALWAYS work with our patients directly. If you are having difficulty paying your bill, please call our billing department. Any balances that remain unpaid after 90 days may be forwarded to our collection agency. If your account is forwarded to collection, you will assess additional fees.

I have read the above payment notice and understand my financial responsibility. If I have additional questions I understand that I may speak with one of the office staff members or a billing representative.

_____ _____
Patient Printed Name DOB

_____ _____
Patient Signature Date

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Acknowledgement of Receipt of Notice of Privacy Practice

I understand that as a part of the provision of health services, Peterson Women's Associates creates and maintains health records and other information describing among other things, my health history, symptoms, examination, and test results, diagnosis', treatment and any plans for future care or treatment.

I have received a paper copy of Peterson Women's Associates Notice of Privacy Practices (HIPPA), which explains how my medical information will be used and disclosed.

By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment and healthcare operations. I have the right to revoke this consent in writing, except where disclosures have already been made in reliance on my prior consent.

This consent is given freely with the understanding that:

1. Any and all records, whether witten or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or healthcare operations without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this consent is as valid as the original.
3. I have the right to request that the use of my Protected Health Information, which is used or disclosed for the purposes of treatment, payment or healthcare operations, be restricted. I also understand that the Practice and I must agree to any restrictions in writing that I request on the use and disclosure of my Protected Health information which have been previously agreed upon.

_____ ____/____/____

Patient name DOB

_____ ____/____/____

Signature Date

Our patient was handed a copy of our Notice of Privacy Practices (HIPPA) and a good faith effort to obtain written acknowledgement was made. This effort was declined by the patient.

_____ ____/____/____

Employee signature Date

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PATIENT AUTHORIZATION FOR CONTACT & DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

This information allows us to release you medical information to only the people listed below. Your doctors are always informed, so you do not need to list them.

I authorize Peterson Women's Associates to disclose my protected health information to:

_____ Ph #: _____ Relationship: _____

_____ Ph #: _____ Relationship: _____

_____ Ph #: _____ Relationship: _____

_____ Myself Only (You will be the only person that will receive or obtain information from our office.)

I authorize Peterson Women's Associates to disclose only the following information to the individual(s) listed above:

_____ Test results, reports, and general health updates

_____ Nothing beyond general health questions and updates

_____ Appointment information (date& time)

I authorize Peterson Women's Associates to contact me regarding health information by:

_____ E-mail: _____

_____ Please send detailed email

_____ Please send only call back information

_____ Phone: _____Home / Cell / Work (please specify)

_____ Please leave detailed message on voicemail or answering machine

_____ Please leave information with any of individual(s) listed above

_____ Please leave a message with only call back information

This authorization will remain in effect until terminated by patient, patient's representative, or other individual of legal entity authorized to do so by court order or law by submitting request in writing to our office. You will be asked to update this form each year.

_____ _____

Patient Signature Date