Patient Health History

Patient Name: _____ **Age:** _____ **Date of Birth:** _____

Family Doctor: _____ **Referred By:** _____

Reason for Visit: _____

WARSAW WOMEN'S CENTER

Past Medical History

CONDITION	CURRENT	HISTORY	NO	CONDITION	CURRENT	HISTORY	NO
Abnormal PAP Smear				Herpes			
Anemia				Human Immunodeficiency Virus (HIV)			
Anesthesia Complication				Human Papilloma Virus (HPV)			
Anxiety				Hypertension			
Asthma				Infertility			
Blood Clot in Legs or Lung				Kidney Stone			
Blood Transfusion				Liver Disease			
Breast Disorder				Lupus			
Cancer of the Breast				Migraine			
Cancer, other				Mitral Valve Prolapse			
Cardiovascular Disease				Pelvic Inflammatory Disease			
Chlamydia				Rheumatic Fever			
Depression				Seizures / Convulsions			
Diabetes				Stroke			
Endometriosis				Syphilis			
Epilepsy				Thyroid Disorder			
Fibromyalgia				Trichomoniasis			
Gonorrhea				Tuberculosis			
Heart Murmur				Ulcer			
Hepatitis B				Urinary Tract Infection			
Hepatitis C							

Date of Last Pap Smear: / / Normal Abnormal **Date of Last Mammogram: / / Normal Abnormal**

Date of Last Dexa Scan: / / Normal Abnormal **Date of Last Colonoscopy: / / Normal Abnormal**

Other:

Operations / Surgeries

TYPE OF SURGERY	DATE	TYPE OF SURGERY	DATE
1)		4)	
2)		5)	
3)		6)	

Medications

Include prescriptions, over-the-counter, herbals, and vitamins

MEDICATION	DOSAGE	PRESCRIBING PHYSICIAN
1)		
2)		
3)		
4)		
5)		
6)		

Medication Allergies

Latex Allergy: Are you allergic to latex? (circle) **YES** **NO**

MEDICATION	REACTION
1)	
2)	
3)	

Over, Please

Family Medical History

Do any of your children, siblings, grandparents (maternal/paternal), or parents have any of the following?

ILLNESS	YES	RELATIONSHIP	ILLNESS	YES	RELATIONSHIP
None			Cardiovascular Disease		
Adopted			Depression		
Blood Clot in Legs or Lungs			Diabetes		
Cancer, Breast			Hypertension		
Cancer, Cervical			Osteoporosis		
Cancer, Colon			Polyp - anal/rectal/colon		
Cancer, Ovarian			Stroke		
Cancer, Uterine			Thyroid Disorder		
Cancer, Other					

Genetic History / Screening

Self, partner, or other family member

CONDITION	YES	RELATIONSHIP	CONDITION	YES	RELATIONSHIP
Cats - do you have exposure?			Ingestion of uncooked meat		
Chickenpox			Patient age > 35 years as of EDC		
Congenital Heart Defect			Phenylketonuria (PKU)		
Cystic Fibrosis			Rh Sensitized		
DES Exposure			Sickle Cell Anemia		
Diabetes - Self only			Tay-Sachs Disease		
Down Syndrome			Thalassemia (Italian, Greek, Mediterranean)		
Infertility			Uterine Defect		

Reproductive History

Age of first menses:	**Cycle Interval** (Number of days from start to start):
Menses Duration (Number of days of bleeding):	**Flow (circle):** Light Medium Heavy
Number of Tampons per day:	**Number of Pads per day:**
Last Menstrual Period (Date): / /	**Certain of LMP Date? (circle):** YES NO
Menopause Status (circle): Pre Peri Post	**Age at Menopause:**
Method of Birth Control:	**Clots (circle):** YES NO
Breakthrough Bleeding (circle): YES NO	**On HRT? (circle):** YES NO

Pregnancy History

Date	Gestational Age	Hours in Labor	Birth Weight	Sex	Type of Delivery	Anesthesia	Early Labor?	Comments / Complications	Hospital

Social History

Marital Status (circle): Divorced Married Single Widowed **Spouse / Partner Name:**_____
Occupation:
Alcohol (check): Never_____ Current_____ Former_____ (If current or former) **Amount per Week**_____
Drugs (check): Never_____ Current_____ Former_____ (If current or former) **Type**_____
Smoking (check): Never_____ Current_____ Former_____ (If current or former) **Amount per Day**_____
Amount of Exercise: Active Heavy Medium Minimal None (Sedentary)

WARSAW WOMEN'S CENTER
1275 Provident Drive
Warsaw, IN 46580

Associated Surgeons & Physicians, LLC G #_____

NOTICE OF FINANCIAL INTEREST IN HEALTH CARE ENTITY

The undersigned individual is hereby notified by his/her treating/referring physician (the "Physician"), who is associated with by Warsaw Women's Center (WWC) that, by virtue of the Physician's association with WWC, the Physician may have part-ownership or a financial interest in one of the hospitals within the Lutheran Network. The Physician believes the Hospital is an appropriate setting for the medical care and services for which the undersigned is being referred. Nevertheless, the selection of a specific health care entity/facility always rests with the patient, and as such, the undersigned may choose to be referred to an alternate entity/facility of his/her choice. The undersigned hereby acknowledges and certifies that he/she has received a copy of the Notice of Financial Interest in Health Care Entity.

CONSENT FOR TREATMENT OF ADULT

I (the patient) hereby consent to the administration of health care (including care, treatment, services, examinations, tests, consultations or procedures to maintain, diagnose or treat me (the patient) by Warsaw Women's Center (WWC). This Consent for Treatment shall specifically include tests for the presences/absence of alcohol or controlled substances. By my signature below, I acknowledge that I am giving my consent to the administration of health care by WWC voluntarily, and that I hereby knowingly and voluntarily enter into this Consent for Treatment. I have been informed and acknowledge that I may withdraw my consent hereunder at any time upon written notice to WWC.

CONSENT FOR TREATMENT OF MINOR

I am the ***(circle one)*** parent/guardian/custodian/legally authorized representative/other _____ (describe) of _____, an un-emancipated minor child who is _____ years of age (hereafter the "Patient") and I have authority to execute this Consent for Treatment on behalf of the Patient. I hereby consent to the administration of health care (including care, treatment, services, examinations, test, consultations or procedures to maintain, diagnose or treat the patient's condition) by Warsaw Women's Center ("WWC") for the Patient. The conditions or limitations, if any, on my consent and the authority delegated to WWC hereunder include: _____
The consent for Treatment shall specifically include tests for the presence/absence of alcohol or controlled substances. By my signature below, I acknowledge that I am giving my consent to the administration of health care by WWC for the Patient voluntarily, and that I hereby knowingly and voluntarily enter into the Consent for Treatment. Due to the Patient's inability to sign this Consent for Treatment, I hereby agree on behalf of the Patient, to sign for the Patient, and to bind the patient to the terms of this Consent for Treatment. I have been informed and acknowledge that I may withdraw my consent hereunder at any time upon written notice to WWC.

AGREEMENT TO PAY

I agree that I am responsible for payment for all services provided to me by Warsaw Women's Center (WWC), subject to limitations set forth in any applicable insurance or other third-party benefits contract. I agree that I will pay all applicable insurance co-payments and deductibles. I further agree that I will pay all other outstanding balances for which I am responsible. Specifically, I will be responsible for any services: which Medicare, Medicaid, Medigap or my insurance or other third-party benefits plan determines are not covered; for which the benefits have been exhausted; for which I fail to obtain any required authorization from my primary care physician; and, for which any spend down amount has not been met. I will also be responsible for any out-of-network fees and for any other amounts which are due and are not required to be written off by the contract WWC has with my insurance or other third-party benefits carrier. I agree to pay such amounts within 30 days of being notified by WWC of the balance due. *I understand that if I fail to pay my balance, my account may be turned over to a collection agency or attorney. In such an event, I agree that I will be responsible for all collection fees (including reasonable legal fees, interest, and court costs).*

ASSIGNMENT OF BENEFITS

I hereby assign to WWC all rights I have to be reimbursed for medical expenses generated by WWC with respect to Medicare, Medigap, Medicaid and/or any other insurance carrier, including any plan or policy of insurance (group or individual), flexible spending account, health savings account, health reimbursement arrangement or similar plan or reimbursement mechanism. This assignment includes all rights that I may have under ERISA, including but not limited to all rights concerning obtaining copies of plan/policy documents, rights to reasonable and customary fee schedules, and rights to appeal any full or partial claim denial for treatment by WWC. In addition, I hereby request that payment of any authorized Medicare benefits, Medigap benefits, Medicaid benefits and or/insurance or other third party benefits be made directly to WWC. If said benefits are not paid directly to WWC, I agree to forward to WWC all payments that I receive immediately upon my receipt. To assist in this process, I authorize any holder of medical information about me to release to CMS, my Medigap insurer, Indiana health Coverage Programs/Medicaid and/or any other insurance or third-party payor and their respective agents any information needed to determine the benefits payable for the services rendered to me.

ACKNOWLEDGEMENT AND RELEASE

I hereby authorize Warsaw Women's Center (WWC) and all physicians and providers involved with my care to release information from my medical records as may be required to any person, corporation, or agency which is legally responsible or which WWC has good cause to believe is legally responsible, for processing and/or paying all or any part of WWC charges and/or professional fees; and, to any entity which has contracted with any insurer to conduct utilization or performance review. I hereby authorize WWC and any affiliated physician or provider involved with my care to release information to any physician or provider to which I may be transferred for further medical care.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I have been offered the opportunity by Warsaw Women's Center to receive a copy of the Notice of Privacy Practices.

PRINTED NAME OF RESPONSIBLE PARTY_____ DATE_____

SIGNATURE OF RESPONSIBLE PARTY_____ RELATIONSHIP TO PATIENT_____

G# _____ **Associated Surgeons & Physicians, LLC (ASAP) dba**

Women's Health Advantage, Warsaw Women's Center, Dupont Internal Medicine, Indiana Wound Care, Center for Colon & Rectal Care

Limited Patient Authorization for Disclosure of Protected Health Information

Please print all information.

Patient Name (printed): _____

Social Security Number: XXX-XX- __ __ __ __ **Date of Birth: _____**

Purpose of request (who will be authorized to receive information) ☐ I authorize the practice to disclose or provide protected health information about me.

Who will provide or disclose information:

Warsaw Women's Center
1275 Provident Dr
Warsaw, IN 46580-3265
574-269-4026

Who will be authorized to receive information (family, friends, others):

Name: _____ Relationship: _____ Phone: ( ) _____

Name: _____ Relationship _____ Phone: ( ) _____

Name: _____ Relationship _____ Phone: ( ) _____

Description of the information to be disclosed ☐ I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above:

- ◯ Entire record, including every category listed below
- ◯ Office notes, labs and x-rays only
  - ◯ Office notes ◯ lab results ◯ x-rays; hospital ◯ pregnancy test results
- ◯ Nursing home, home health, hospice, and other physician records
- ◯ Record of HIV and communicable disease testing, including testing for sexually transmitted diseases
- ◯ Financial history report (previous 3 years only)
- ◯ Only disclose the following _____

Purpose of disclosure (please check the purpose of the disclosure or check patient request):

- ◯ Patient Request
- ◯ Other (please specify): _____

Expirations or termination of authorization: This authorization will expire upon the termination of your physician/patient relationship with ASAP, unless you specify an earlier termination. You have the right to terminate this authorization at any time.

Right to revoke or terminate: As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request to our Privacy Manager.

Non-Conditioning statement: The practice places no condition to sign this authorization on the delivery of healthcare or treatment.

Redisclosure: We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of the practice.

Patient Signature _____ **Date _____**

You have the right to receive a copy of signed authorizations upon request.