



Please help us to update your chart by filling out the information below.

Today's Date: _____

Name: _____ Date of Birth: _____ SS#: _____

Address: _____ City: _____ ST: _____ Zip: _____

Cell #: _____ Home #: _____ Work #: _____

Email Address: _____ Marital Status: _____

Occupation: _____ Company: _____

Insurance Carrier: _____ ID #: _____

Primary Care Physician: _____

Preferred Pharmacy: _____ Location: _____

Gynecological History

Current Height: _____ Current Weight: _____

List first day of last period (date) _____ Any problems with your period (frequent, heavy, painful)? Yes No

Last mammogram (date) _____ Last bone density (date) _____ Last colonoscopy (date) _____

Present birth control (circle): Pill IUD Ring Shot Implant Condoms Rhythm method/withdrawal Tubal/vasectomy

Are you happy with it? Yes No

Please **list all current** medications/vitamins with dose _____

Do you have any **allergies/reactions to medication**: Yes No What? _____

In the **last year** has any member of your family been diagnosed with breast, ovarian or uterine cancer? Yes No

Please list family relation and age at diagnosis _____

Please **list all surgeries** and date they occurred _____

Do you smoke cigarettes? Yes No Do you consume alcohol? No Daily Sometimes Do you do drugs? Yes No



Authorization Form for Release of Protected Health Information with Family or Friends

Patient Name: _____ **DOB:** _____

I grant permission for my healthcare provider and their representatives of CPWC to discuss my care using this disclosure form to share relevant information about my healthcare or discuss financial information for payment on my account with family or friends.

➤ **I consent to CPWC to leave a detailed message on my voicemail/answering machine regarding my lab/test results** Yes No

I do not want any of my information shared with family or friends

Release my protected health information to the following person(s)/entity:

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

The information you may release subject to this authorization is following:

Appointment date/time Yes No Explanation of diagnosis and/or procedures Yes No

Lab reports Yes No Billing information Yes No

I understand that my healthcare information at Cedar Park Women's Center is protected. I have received this Notice of Privacy Practices and this document will be on record with CPWC.

Patient Signature

Date

This consent will be considered valid until such time that I revoke it. I reserve the right to revoke it at any time. I understand that to revoke this consent, I must provide written notice to Cedar Park Women's Center.



Cedar Park Women's Center Patient Consent Form

By signing this form, you are granting consent to Cedar Park Women's Center to use and disclose your protected health information for the purpose of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have legal right to review our Notice of Privacy Practice before you sign this consent and we encourage you read it in full.

Our Notice of privacy practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting our health information officer at: (512) 260-3636.

You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment, or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

Patient Names (Print): _____

Signature: _____

Date: _____

Office Use Only:

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this acknowledgement but did not because _____.

Signature of Privacy Officer



Please read, initial and sign below

(Initial) _____ **FINANCIAL RESPONSIBILITY:** I understand that payment is due at the time of service. I understand that I am ultimately responsible for payment on my account. This may include but not limited to:

- *Entire balance when there is no insurance coverage; with insurance coverage, all and any co-pays, co-insurances and deductible payments.*
- *Any balances due within 30 days after insurance has been processed.*

I understand that I am responsible for any authorization or referral my insurance may require, and verification of IN-NETWORK status prior to the time of service. I understand that I am ultimately responsible for payment on my account.

(Initial) _____ **LAB SERVICES:** I am aware that any samples collected at my visit (Blood, Urine, Tissue, Genetic Testing, etc) are sent to an outside lab for processing. I understand that these services will be billed to me separately by the lab. I will need to contact the lab directly for their charges.

(Initial) _____ **INSURANCE COVERAGE:** I understand that it is my responsibility to update Cedar Park Women's Center with current, accurate insurance information at each visit. I will be responsible for any balance due as a result of not disclosing this information.

(Initial) _____ **FEE FOR FMLA/DISABILITY FORMS COMPLETION:** I understand that I will be responsible for paying \$25.00 for forms completions by Cedar Park Women's Center or staff. *This does not include the New Patient Forms. (Example: FMLA forms, disability forms, etc.)* Please allow 10 business days for completion of any forms, and plan accordingly. This fee is due prior to the forms being completed, and is not covered by insurance.

(Initial) _____ **FEE FOR MATERNITY SONOGRAM CD:** We can make a CD of your Anatomy Sonogram pictures for \$15.00. This fee is due at the time of the sonogram, and is not covered by insurance.

(Initial) _____ **FEE FOR MISSED APPOINTMENTS:** I understand that there is a \$40.00 fee for missing a scheduled office visit appointment. If you are scheduled for an ultrasound the fee is \$50.00. We require 24 hour notice for appointment cancellation. This is not covered by insurance.

Patient Name: _____

Signature: _____

Date: _____