Clarksville Women's Center
Obstetrics & Gynecology

Welcome to Our Office! **Date:** _____

Patient's Name: _____ Social Security # : _____
Birth Date: _____ Age: _____ Marital Status: Sing Mar Wid Divor Separ
Cell Phone #: _____ Home Phone #: _____
Street Address: _____
City: _____ State: _____ Zip: _____

Race: Black/African American
White
American Indian/Alaska Native
Asian
Native Hawaiian
Other Pacific Islander

Ethnicity: Latino or Hispanic Identity
Not Latino or Hispanic
Unreported/Refused to Report

Language: Chinese
English
French
Spanish
Other

Referring Physician: _____ Family Physician: _____

Patient's Employer: _____ Occupation: _____
How Long Employed: _____ Business Phone #: _____
Employer Address: _____ _____
City: _____ _____ State: _____ Zip: _____

Spouse or Parent's Name: _____
Spouse or Parent's Social Security #: _____Birth Date: _____
Patient's Employer: _____ Occupation: _____
How Long Employed: _____ Business Phone #: _____
Employer Address: _____ _____
City: _____ _____ State: _____ Zip: _____

Emergency Contact: _____Relationship: _____
Phone #: _____
Nearest Relative (Not living with you): _____Relationship: _____
Phone #: _____

Insurance Authorization and Assignment

Insurance: _____ Name of Policy Holder: _____

I request that payment of authorized Medicare/other insurance company benefits be made either to me or on my behalf to Drs. Bendt & Riestra for any services furnished me by that party who accepts assignment/physician. Regulations pertaining to Medicare Assignment of Benefits apply.

I authorize any holder of medical or other information about me to release to the Social Security Administration and health care financing administration or its intermediaries or carriers any information needed for this or a related Medicare claim / other insurance company claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 11288 of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.

Signature: _____ Date: _____

Clarksville Women's Center
GYN Record

Name _____ Date_____

Chief Complaint (Reason for your visit today)

_____

_____

Past Medical History

Hospitalizations and Surgeries _____Year _____

_____Year _____

_____Year_____

Have you or any relative had difficulties with anesthesia? _____

Have you had a blood transfusion? _____ Did you have any difficulties with the transfusion?_____

Do you have any allergies to medication or other?

_____

_____

Are you taking any medications?

_____

_____

Please provide your pharmacy. _____ Location _____

Habits	Smoking	Yes / No	Number of packs per day _____
	Alcohol	Yes / No	Number of drinks per week_____
	Coffee	Yes / No	Number of cups per day _____
	Street Drugs	Yes / No	Name and Frequency_____

Have you or a family member had any of the following:

	Patient	Family		
		Maternal	Paternal	
Weight Loss or Gain	☐			_____
Appetite Change	☐			_____
				_____
Headaches / Migraines	☐	☐	☐	_____
Convulsions / Epilepsy	☐	☐	☐	_____
Depression	☐	☐	☐	_____
Mental Disorder	☐	☐	☐	_____
Stroke	☐	☐	☐	_____
High Blood Pressure	☐	☐	☐	_____
Heart Disease	☐	☐	☐	_____
Respiratory Disease	☐	☐	☐	_____
Breast Disease	☐	☐	☐	_____
Jaundice / Hepatitis	☐	☐	☐	_____
Gall Bladder Disease	☐	☐	☐	_____
Ulcers / Digestive Problems	☐	☐	☐	_____
Bowel Disease	☐	☐	☐	_____
Kidney Disease	☐	☐	☐	_____
Anemia/Bleeding Disorder	☐	☐	☐	_____

Have you or a family member had any of the following:

	Patient	Family		
		Maternal	Paternal	
Varicose Veins/Phlebitis	☐	☐	☐	_____
Thyroid Disease	☐	☐	☐	_____
Diabetes	☐	☐	☐	_____
Skin Disease	☐	☐	☐	_____
Arthritis	☐	☐	☐	_____
Cancer Breast	☐	☐	☐	_____
Cancer Genitalia	☐	☐	☐	_____
Cancer Other	☐	☐	☐	_____

Gynecologic History

How old were you when you started your periods? _____
When was your last period? _____
How many days do your periods last? _____
Are they light, moderate or heavy? (Circle One)
Do you have cramping with your periods? Mild, moderate, or severe? (Circle One)
What other problems do you have with your period? _____
Do you have bleeding after intercourse? _____
Do you have any sexual difficulties? _____
Do you have problems with vaginal infections or discharge? _____
Have you had any sexually transmitted diseases? _____
Do you have HIV? _____
Do you have recurrent urinary infections? _____
Do you lose urine when you run, cough, or sneeze? _____
Have you had pelvic infections? _____
Are you currently on any type of birth control? _____
Have you had any abnormal PAP smears? _____
Have you had a mammogram? _____ Normal / Abnormal _____When? _____

Obstetrical History

Year	Duration of Pregnancy	Duration of Labor	Anesthesia	Type of Delivery	Sex	Weight	Complication

Patient Consent & Payment Agreement

Consent for Medical Care

I voluntarily consent for medical care at Clarksville Women's Center which may include examination, tests, photographs, and treatments by physician(s) and staff. No promises have been made to me as to the result of treatment or examination.

Solstas Lab Partners

Clarksville Women's Center coordinates lab care with Solstas Lab Partners. In the event you receive a bill and have question, please contact Solstas Lab Partners at 1-888-664-7601, and speak with a customer service representative.

Fees & Payments

As a courtesy to patients, Clarksville Women's Center is pleased to assist in the submission of medical insurance claims to insurance companies for payment. I understand that it is my responsibility to confirm the provider I see at Clarksville Women's Center is a participating provider under my policy. Further, I understand that my insurance company may not cover 100% of my bills for services provided, and that I will be responsible for the payment of any remaining balance due.

I understand that it is my responsibility to provide Clarksville Women's Center with appropriate and current insurance information – and to notify Clarksville Women's Center immediately upon any change in my insurance coverage – to ensure efficient claims billing and payment. In the event that I fail to provide all necessary and current insurance information, I understand that my insurance company(ies) may deny payment of claims relating in services rendered to me, and I understand that I may be fully responsible for my entire account balance.

Furthermore, I understand that it is my responsibility to have obtained any and all necessary referrals and authorizations required prior to treatment by Clarksville Women's Center. If my insurance company requires a referral and I do not have one, then I understand that I will be responsible for the entire bill for rendered services.

I understand that I will be responsible for paying co-payments, deductible, and any fees relating to services rendered that are not fully (or at all) covered by my insurance company(ies). I understand that if my insurance requires a co-pay, the co-pay is required at the time of service, and that a $10 service charge may be added to any bill sent to collect a co-pay.

Assignment of Benefits

I hereby authorize payment of all medical insurance benefits which are payable to me under the terms of my insurance policy to be paid directly to Drs. Bendt and Pruthi for services rendered. I further consent to the use and disclosure of protected health information as regulated by HIPAA, and authorize the release of any information needed for the purposes of treatment, payment and health care operations, including, but not limited to the processing these insurance claims.

Patient Discharge / Collection Fees

In the event of failure to pay for medical services rendered, I understand that I may be discharged from the services of Clarksville Women's Center until such time as my account is paid. Additionally, I understand that I may be referred to a collections agency for non-payment of fees due for services rendered by Clarksville Women's Center. I understand that I will be responsible for a 30% collection fee, all agency and attorney fees and costs associated with the collection process (such as court costs), and that these fees and costs will be added to my account balance.

I understand that I will be responsible for paying the entire amount of my balance due in addition to the collection agency fee. Further, I understand that my PHI will necessarily be revealed in these efforts to collect payment of monies owed.

Returned Check Fee
I understand that in the event that my check is returned for insufficient funds, I agree to provide cash, money order, or certified check for the full amount of payment owed, in addition to a $30.00 returned check charge.

Missed Appointment Fee
I understand that I will be assessed a $25.00 fee if I miss an office visit without having provided a 24-hour advance notice of cancellation.

Transfer of Records
I understand that I will be charged a fee for the costs of reproduction, copying, or mailing records in stated in Section 63-2-102 when requesting my records. The State of Tennessee mandates twenty dollars for medical records forty (40) pages or less in length, twenty-five cents (25) per page for each page copied after the first forty, and mailing of records. This payment is due in full prior to the copying and forwarding of records.

Annual Examination
Please note the Healthcare Financing Administration defines an annual well woman examination as the collection of Pap smear, beast examination, and family planning/birth control counseling. If you are experiences any problems, please feel free to discuss with the physician. Due to the severity and length of problem, an additional code may be billed to your insurance carrier as the problem is not included in the scope of a well woman examination.

HIPAA Acknowledgement of Receipt of Notice of Privacy Practices
We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice of Privacy Practices.

Tenncare Questionnaire

1) Have you ever been enrolled in Tricare or Champus? Yes No
   (Answer yes if your guardian, parent, or spouse was in the military and had you listed as a dependent).
2) Are you still enrolled in Tricare? Yes No
   If so, please list the sponsor name and ID #. _____
3) Do you have coverage with a commercial insurance at this time or plan to in the near future? Yes No
   Please list the insurance and Policy # you are covered under or may be receiving in the near future.
   _____

Please understand that if you do have other insurance besides Tenncare but do not present the card at the time of service, you may be reported to the Tenncare Fraud and Abuse Department. You will also be responsible financially for any money Tenncare recoups for services rendered.

Patient Signature: _____

Date: _____/_____/_____