Today's Date ____/____/____

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patient Name Last First Middle	☐ Mr ☐ Mrs ☐ Miss ☐ Ms	Marital Status (circle) Single/ Married / Divorced /Sep/ Widow
Is this your legal name? ☐ YES ☐ NO	If not, what is your legal name?	Birthdate / /	Age Sex ☐ M ☐ F ☐ T
Street or Mailing Address (circle one) City State Zip Code		Home Phone Number ( )
Cell Phone Number ( )	E-Mail Address	Social Security - -
Occupation	Employer	Employer Phone Number

Employment Status: ☐1 – Full-Time ☐2 – Part-Time ☐3 – Not Employed ☐4 – Self-Employed ☐5 – Retired ☐6 – Active Military
Student Status: ☐F – Full-Time Student ☐P – Part-Time Student ☐N – Not a Student

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

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Declined

Language: ☐English ☐Spanish ☐Indian ☐Japanese ☐Chinese ☐Korean ☐French ☐German ☐Russian ☐Other _____

Pharmacy:	Do you have a living will? ☐ YES ☐ NO

Referred By (Please check one box)
☐ Dr. _____ ☐ Insurance ☐ Hospital ☐ Family ☐ Friend ☐Yellow Pages ☐ Other _____

Other Family Members Seen Here

PCP Name Phone #

RESPONSIBLE PARTY INFORMATION

Responsible Party: ☐Another Patient ☐Guarantor ☐Self ☐Check here if information is same as patient

Name	Address	Home Phone Number
Birth Date / /	E-Mail Address	( )
Occupation	Employer	Employer Address	Employer Phone Number ( )

INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Is this visit for one of the following? ☐ WORKERS COMPENSATION (WC)
☐ OCCUPATIONAL MEDICINE (OM) ☐ MOTOR VEHICLE ACCIDENT (MVA) ☐ ACCIDENT DATE _____

Does the patient have healthcare coverage? ☐ YES ☐ NO	**Insurance Name**				
Name of Insured	Social Security Number - -	Birth Date / /	Effective Date / /	Group ID	Subscriber ID (Policy Number)
Patient Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other _____					
Name of Secondary Insurance	Name of Insured		Date of Birth / /	Group ID	Subscriber ID (Policy Number)
Patient Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other _____					

EMERGENCY CONTACT

Name (Last, First)	Relationship to Patient	Home Phone Number ( )	Other Phone Number ( )

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

_____ _____

Patient/ Guardian Signature Date

Sumner Women's
ASSOCIATES
OBSTETRICS & GYNECOLOGY

HIPAA ACKNOWLEDGEMENT, PATIENT CONSENT AND FINANCIAL POLICY

I. **CONSENT FOR TREATMENT:** I hereby consent to the performance of such diagnostic procedures and/or medical treatment as deemed necessary or advisable by my physician(s). I hereby consent to the performance of all nursing and technical procedures and tests as directed by my physician(s). I understand that my medical care may require the collection of samples, including fluids or tissues, from my body. This may include having blood drawn or tissues removed during tests, treatment, or surgery. Further, I understand that should any medical personnel or other person(s) be exposed or report an exposure to my blood or body fluids, my blood will be tested for blood borne infections including Hepatitis Band C as well as HIV/AIDS. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatments or examination. I have the right to refuse tests or treatment (as far as the law allows) and to be told what might happen if I do. I have the right not to have any photos or videos taken of me unless I agree to this, except as needed to treat me. I intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended. This consent will remain in full force until revoked in writing.

II. **NOTICE OF PRIVACY PRACTICES:** Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Acknowledgement. The terms of our Notice may change; if we change our notice, you may request a revised copy by contacting our office or you will receive a new notice the next time you are treated at our office. The Clinic provides this form to comply with the Health Information Portability and Accountability Act of 1996 (HIPAA).

_____
Patient Initials

The patient understands that:

- The practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice.
- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The practice reserves the right to change the notice of privacy practices.

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings, and care decisions to the individuals listed below. Please note that this does not allow these individuals to obtain copies of my medical records without a complete and valid authorization from me.

NAME	RELATIONSHIP	CONTACT NUMBER

III. **ELECTION TO ELECTRONICALLY TRANSMIT MEDICAL INFORMATION:** I authorize Clinic to provide a copy of the medical record of my treatment, and a summary of care record to my primary care physician(s), specialty care physician(s), and/or any health care provider(s) or facility(ies) to facilitate my treatment and continuity of care. I understand that information disclosed under this paragraph may include, among other things, confidential HIV-related information and other information relating to sexually transmitted or communicable diseases, information relating to drug or alcohol abuse or drug or alcohol dependence,, mental or behavioral health information (excluding psychotherapy notes), genetic testing information, and/or abortion-related information. The summary of care record consists of information from my medical record, including among other things, information concerning procedures and lab tests performed during this episode of care, my care plan, a list of my current and historical problems, and my current medication list. I understand that I may, by placing my request in writing to the Clinic, revoke this authorization at any time. However, I understand that a healthcare organization cannot take back information that has already been released under this authorization. This authorization will expire automatically one year after the date on which my current treatment episode comes to an end.

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IV. **PARTICIPATION IN HEALTH INFORMATION EXCHANGE(S):** Federal and state laws may permit this Clinic to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I hereby authorize Clinic to provide a copy of my medical record or portions thereof to any health information exchange or network with which Clinic participates and to any other participant in such health information exchange or network for purposes of treatment, payment, health care operations, and the purposes discussed above, and in accordance with the terms of the participation agreement for that health information exchange or network. A full list of health information exchanges and/or networks with which Clinic participates may be found in the Notice of Privacy Practices, which is available on the Clinic website, and this list may be updated from time to time if and when Clinic participates with new health information exchanges or networks. I understand that information disclosed under this paragraph may include, among other things, confidential HIV-related information and other information relating to sexually transmitted or communicable diseases, information relating to drug or alcohol abuse or drug or alcohol dependence, mental or behavioral health information (excluding psychotherapy notes), genetic testing information, and/or abortion-related information. I understand that I may, by placing my request in writing to the Privacy Officer, revoke this authorization at any time. However, I understand that a healthcare organization cannot take back information that has already been released under this authorization. This authorization will expire upon revocation.

V. **EMAIL AND TEXT COMMUNICATIONS:** If at any time I provide an email or text address at which I may be contacted, I consent to receive calls or text messages, including but not restricted to communications regarding billing and payment for items and services, unless I notify the Clinic to the contrary in writing. In this section, calls and text messages include but are not restricted to pre-recorded messages, artificial voice messages, automatic telephone dialing devices or other computer-assisted technology, or by electronic mail, text messaging, or by any other form of electronic communication from Clinic, its affiliates, contractors, servicers, Clinical providers, attorneys, or agents, including collection agencies. Practice may contact me via email and/or text messaging to remind me of an appointment, to obtain feedback on my experience with the Practice's healthcare team, and to provide general health reminders/information.

VI. **FINANCIAL POLICY:** The undersigned, in consideration of the services to be rendered to the patient, is obligated to pay the medical practice in accordance with its regular rates and terms, and if the account is referred to an attorney or agency for collections, to pay reasonable attorney's fees and collection expenses. The undersigned hereby assigns to the medical practice all insurance benefits for services provided.

- The Clinic will file your insurance as a courtesy to you; however, you are responsible for the entire bill. **All co-payments, unmet deductibles, and other patient-responsible services must be paid at the time of the visit.** If your insurance carrier applies the billed charges to your deductible, denies the services, or considers the services non-covered, you are responsible for payment of the service. **If you do not have insurance, payment in full will be expected at the time of the visit.**

- In the event your insurance company does not pay the claim within a reasonable amount of time (45-60 days), then you may become responsible for the bill. If payment is not received within a reasonable amount of time from the guarantor, or if we receive returned mail as undeliverable, we will place your account with an outside collection agency.

- If your insurance plan requires a referral or prior authorization, you must present this along with your insurance ID at each visit. If you do not have the referral when you arrive for your appointment, payment for the visit becomes your responsibility.

- Returned checks will be subject to a returned check fee. A fee may be charged for missed appointments.

VII. **PATIENT'S CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION, AND PAYMENT REQUESTS:** If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate State agency for payment of a Medicaid claim. I certify the information given by me in applying for payment under Title XVIII of the Social Security Act (Medicare) is correct. I request that payment of assignment benefits be made on my behalf.

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I acknowledge receipt of the HIPAA Acknowledgement and Consent Form. I further acknowledge that I have been given the opportunity to ask questions.

_____ _____

Printed Name of Patient or Representative Signature of Patient or Representative

_____

Date

Relationship to Patient (if other than patient) _____

CLINIC STAFF USE ONLY

□ Check if patient refused to take a copy of the Notice of Privacy Practices

State reason for refusal, if known:

_____ _____

Witness (Staff) Signature Witness (Staff) Printed Name

Date: _____

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CANCELLATION AND NO SHOW POLICY

We understand that situations arise in which you must cancel your appointment. We request timely notification to our practice to enable another patient, waiting for an appointment, to be scheduled. Our goal is to provide the highest quality of care and service to you and other patients.

Please review our policy below:

- **Scheduled Procedures**
  - **48 hours notice** is.required to be timely
  - **$100 fee** for a "No-Show" or Cancellation without timely notice

- **Office Appointment**
  - **24 hours notice**.is required to be timely
  - **$25 fee** for a "No-Show" or Cancellation without timely notice

The definition of a "No Show" is an appointment for which the patient does not attend and has not provided a call to cancel the office appointment or procedure appointment. **Patients who incur a "No-Show" or untimely Cancellation two (2) or more times in a 12 month period, may be required to obtain a new referral from their Primary Care Physician.**

No Show/Untimely Cancellation fees are billed directly to the patient after the date of the missed appointment. These fees must be paid in full before the patient's next appointment. **Unfortunately, insurance does not cover this fee for the patient.**

We understand that special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived with management approval.

Our practice firmly believes that a good physician/patient relationship is based upon understanding and good communication. **Please note that it is the patient's responsibility to call and reschedule a follow-up appointment in the event of a No Show or Cancellation to ensure that you are able to obtain proper care.**

Questions about cancellation and no show fees should be directed to the Billing Department (615-328-5253). Please sign that you have read, understand and agree to this Cancellation and No show Policy.

Patient Name (Please Print) _____ Date _____

Date of Birth _____

Signature of Patient or Patient Representative _____

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Permission to give medical information to others

Patient Name: _____ Date of Birth: _____

If you allow other individual(s) to receive medical information on your behalf including test results and appointment reminders, please list the name(s) of the individual(s) below:

Name: _____Phone#_____

Name: _____Phone#_____

Name: _____Phone#_____

If you wish that we give any and all results to no one but you, please initial here_____

May we leave messages regarding your medical information (such as appointment information, imaging results, and labs on your voicemail/answering machine?

(Yes) home#_____ cell#_____ work#_____ (No)_____

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Menstrual History

Date of last menstrual period: _____ **How often do you have your period?** _____

Is your bleeding: ☐Light ☐Moderate ☐Heavy How many days does the bleeding last? _____

How many days do your periods last? _____ Do you have spotting or bleeding between periods? ☐Yes ☐no

Menstrual Symptoms: (please check all that apply)

☐Cramps ☐Severe Pain ☐Bloating ☐Breast Tenderness ☐Severe Emotional Change ☐Nausea

Post-Menopausal:

What age did your periods stop? _____ Are you experiencing any vaginal bleeding? ☐ Yes ☐ no Have you ever been on Hormone Replacement Therapy?

☐ Yes ☐ No if yes, please list type: _____

Gynecological History

Approximate date of last gynecological exam? _____ Did you have a pap smear at that visit? ☐Yes ☐ No

Did you have a breast exam at your last gynecological visit? ☐ Yes ☐No Have you had a mammogram? ☐Yes ☐no

Date of most recent mammogram: _____ Have you had a colonoscopy? ☐Yes ☐no date of colonoscopy: _____

Check if you have had any of the following:

☐Abnormal Pap ☐Positive HPV test ☐Genital Herpes ☐ Gonorrhea ☐Chlamydia ☐Pelvic Inflammatory Disease (PID)

☐Frequent Urinary Tract Infection ☐Ovarian Cyst ☐Endometriosis ☐Fibroid Uterus ☐Infertility

Sexual History

Are you sexually active? ☐Yes ☐No with: ☐Men ☐Women ☐Both

Do you experience pain or other difficulties with sexual activities? ☐ Yes ☐No

Do you feel safe at home? ☐Yes ☐ No Have you ever been hurt or frightened during sex? ☐Yes ☐No

If yes, specify: _____

CONTRACEPTIVE HISTORY ☐ none (does not apply)

What form of birth control are you currently using? ☐condoms ☐birth control pills ☐depo provera ☐patch

☐Mirena ☐Nexplanon ☐Diaphragm ☐spermicide ☐withdrawal ☐other _____

Other methods used in the past: _____

Are you interested in changing type of birth control? ☐ Yes ☐no

OBSTETRICAL HISTORY:

Have you ever been pregnant? ☐Yes ☐ No Have you ever had an abortion? ☐Yes ☐No

How many pregnancies have you had? _____ How many living children? _____ Any complications with previous pregnancies? ☐Yes ☐no
(If yes, please specify)

_____

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MEDICATIONS

PLEASE LIST ALL CURRENT MEDICATIONS INCLUDING NON-PRESCRIPTION MEDICATIONS AND THE DOSAGE:

Pharmacy Name: _____ **Phone #** _____ **City:** _____

Do you have any drug allergies? ☐Yes ☐no If yes please list below:

_____

_____

Do you have any non-medication allergies? ☐Yes ☐No

☐latex ☐iodine ☐CT contrast dye ☐bee stings ☐shell fish ☐other _____

Do you have an objection to receiving blood products in the case of an emergency? ☐yes ☐no

Did you receive a flu vaccine this year? ☐ yes ☐ no Date of flu shot: _____

Please list all surgeries you have had:

Surgery	**Date/year performed**

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HEALTH HISTORY

Do you currently smoke cigarettes? ☐No, never ☐have exposure to second hand smoke

☐Yes amount per day _____ how many years _____ ☐quit: Date stopped: _____

Do you drink alcohol? ☐yes ☐no how many years: _____

Do you use recreational drugs? ☐ Yes ☐No ☐past user If yes what drug(s) _____

Please list all medical problems that you have or have had:

_____

_____

_____

PLEASE CHECK ALL THAT APPLY

☐ self	☐family	Breast Cancer	☐ self	☐family	Thyroid Problems
☐ self	☐family	Ovarian Cancer	☐ self	☐family	Migraines
☐ self	☐family	Uterine Cancer	☐ self	☐family	Depression
☐ self	☐family	Cervical Cancer	☐ self	☐family	Elevated Cholesterol
☐ self	☐family	Colon Cancer	☐ self	☐family	Liver Disease
☐ self	☐family	High Blood Pressure	☐ self	☐family	Kidney Disease
☐ self	☐family	Diabetes	☐ self	☐family	Bleeding Disorders
☐ self	☐family	Stroke	☐ self	☐family	Gallbladder Disease
☐ self	☐family	Heart Disease	☐ self	☐family	Other:
☐ self	☐family	Seizures			

SUMNER WOMEN'S ASSOCIATES

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient's Name: _____ Date of Birth: _____

Social Security #: _____

I authorize my medical records to be released from: _____

Medical Office Address: _____

City, State, Zip: _____

Doctor's Phone #: _____ Fax #: _____

Release my Medical Records to:

Sumner Women's Associates
Terri Holt, MD
Emily Bienvenu, MD
Jessica Pugh, MD
300 Steam Plant Road, Suite 270
Gallatin, TN 37066
Phone: (615)328-3390 Fax: (615)328-3391

For the purpose of: (please mark)

- o Permanent transfer to a new provider
- o Continuity of medical care
- o Insurance or other third part reimbursement
- o Other: (please specify)_____

This release specifically includes: (please mark all that apply)

- o Complete medical records
- o Office notes
- o Radiology reports
- o Laboratory reports
- o Other: (please specify) _____

Specific dates of service: _____

I acknowledge, and hereby consent to such, that the release of information my contain information regarding alcohol, drug abuse, psychiatrists, HIV/AIDS testing and other sensitive information. (Please initial) _____. I may refuse to sign this authorization and my treatment will not be conditioned upon signature of this authorization. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, should I ask for it. I will receive a copy of this form after I sign it or a copy will be maintained in my permanent record. I have read and authorize the disclosure of the protected health information as stated:

_____ _____

Patient/Guardian Signature Date