

## **WOMEN'S HEALTH FOR LIFE, INC.**

1005 Bellefontaine Ave., Suite 175  
Lima, OH 45804  
Tel. No.: 419-227-2727  
Fax No.: 419-227-2737

770 W. High St, Suite 400  
Lima, OH 45801



Thank you for selecting Women's Health for Life, Inc. to provide your OB/GYN care.  
Your appointment is scheduled for:

To make your first appointment run smoothly, please complete the enclosed information and bring it with to your appointment. Any transferred records we receive from a previous physician are always kept confidential and will not be disclosed without your written permission.

HIPAA: If the patient is a minor, for any results to be released to the patient's parents, the patient must sign an authorization to release information form.

Our office hours are Monday thru Friday from 7:30-11AM and 12-4:30PM. We lunch from 11AM till noon.

ALL prescriptions and authorizations for renewals must be requested during normal office hours. Normal test results will be mailed to you unless you have a return appointment. Any abnormal results will be called to you.

There may be instances when you will see a mid-level provider within our office.

### **PATIENT RESPONSIBILITIES:**

1. If you are unable to keep your appointment, you must notify this office at least 24 hours in advance.
2. If you are fifteen minutes late, your appointment WILL be rescheduled.
3. Please notify our office immediately of any changes in your insurance, address, phone number.
4. If we are providers for your insurance, you will be asked to pay your deductible or co-pay at the time of service. If you are self-pay you will need to pay for your visit in full.
5. Accepting all forms of payment, cash, check, debit or credit cards (do not accept Discover or American Express)
6. You are responsible to know how your insurance plan works.
7. You are responsible to tell the nursing staff if your insurance requires you to use a certain lab (ex:pap specimen, cultures, labs, etc.)

### **FEES NOT COVERED BY INSURANCE:**

1. Third occurrence of not presenting for a scheduled appointment-\$28
2. Prescriptions rewritten - \$11
3. Disability, FMLA forms - \$6 per form
4. Non-sufficient funds returned check fee - \$33

Please bring the following to your appointment:

1. The forms included with this letter
2. Photo of yourself (this photo will be returned)
3. Your insurance card
4. Any questions for the practitioner

We are glad you have chosen us to provide your care. The mission of our medical practice is to provide women with the best of care. We treat all patients with courtesy and respect and we expect our patients to return that courtesy to our personnel.



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**Patient Information**

770 W. High St., Suite 400  
 Lima, OH 45801

<b>Ms / Mrs</b> <small>Circle One</small>	<b>First Name</b>	<b>MI</b>	<b>Last Name</b>	
<b>Address</b>		<b>City</b>	<b>State</b>	<b>Zip Code</b>
<b>Home Telephone</b> <small>Preferred #</small>	<b>Cell Phone</b>	<b>Date of Birth</b>	<b>Spouses name</b>	
<b>Social Security Number</b>				
<b>Pharmacy Name</b>		<b>Pharmacy Address</b>		
<b>Marital Status</b> <b>S</b> <b>M</b>				
<b>Emergency Contact</b>	<b>Relationship</b>	<b>Emergency Contact Phone Number (Other than home number)</b>		
<b>Employed By (Patient)</b>		<b>Work Telephone</b>	<b>Ext</b>	
<b>Address of Employer</b>		<b>City</b>	<b>State</b>	<b>Zip Code</b>
<b>Primary Insurance Plan</b>		<b>Social Security Number of Policy Holder</b>		
<b>Policy Number</b>	<b>Group Number</b>	<b>Expiration Date</b>		
<b>Name of Policy Holder</b>	<b>Date of Birth</b>	<b>Relation to Insured</b>		
<b>Address</b>		<b>City</b>	<b>State</b>	<b>Zip Code</b>
<b>Telephone Number</b>	<b>Employer of Policy Holder</b>		<b>Employer Phone</b>	
<b>Secondary Insurance Plan</b>		<b>Social Security Number of Policy Holder</b>		
<b>Policy Number</b>	<b>Group Number</b>	<b>Expiration Date</b>		
<b>Name of Policy Holder</b>	<b>Date of Birth</b>	<b>Relation to Insured</b>		
<b>Address</b>		<b>City</b>	<b>State</b>	<b>Zip Code</b>
<b>Telephone Number</b>	<b>Employer of Policy Holder</b>		<b>Employer Phone</b>	

**PLEASE READ AND SIGN THE FOLLOWING: Thank You**

Authorization for Treatment: I authorize Women's Health For Life, Inc. and it's staff to provide routine examinations, diagnostic tests, procedures and treatments as deemed necessary. By signing, I give consent for the above and I understand that this consent will remain in effect until I withdraw it in writing.

<b>Signature</b>	<b>Parent or Guardian Signature if Minor</b>
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<b>Date</b>
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**Patient Name:** \_\_\_\_\_

Are you sexually active? Yes \_\_\_ No \_\_\_  
Age of first sexual encounter \_\_\_\_\_ Number of partners (Lifetime) \_\_\_\_\_  
History of sexually transmitted disease? Yes \_\_\_ No \_\_\_ What \_\_\_\_\_ When \_\_\_\_\_  
Did you receive treatment? Yes \_\_\_ No \_\_\_

Are you using birth control? Yes \_\_\_ No \_\_\_ Method? \_\_\_\_\_  
Problems with current birth control? \_\_\_\_\_  
Vasectomy? Yes \_\_\_ No \_\_\_ Tubal ligation Yes \_\_\_ No \_\_\_

Do you perform self breast exams? Yes \_\_\_ No \_\_\_ Last mammogram? \_\_\_\_\_ normal abnormal  
Last pap smear \_\_\_\_\_ normal abnormal History of abnormal pap smear? \_\_\_\_\_  
Last bone density study/Dexa scan \_\_\_\_\_ normal abnormal  
Last Colonoscopy \_\_\_\_\_ normal abnormal

If you are postmenopausal:  
Are you on hormone replacement? Yes \_\_\_ No \_\_\_ If yes what? \_\_\_\_\_  
Did you have a hysterectomy? Yes \_\_\_ No \_\_\_ Do you have your ovaries? Yes \_\_\_ No \_\_\_

Do you get immunizations? Yes \_\_\_ No \_\_\_  
Last flu shot \_\_\_\_\_ Last pneumonia shot \_\_\_\_\_ Shingles vaccine \_\_\_\_\_ Other \_\_\_\_\_  
Have you had chicken pox before? Yes \_\_\_ No \_\_\_ Have you had the chicken pox vaccine? Yes \_\_\_ No \_\_\_  
Last Tetanus/Diphtheria/and Pertussis vaccine \_\_\_\_\_

Medication name	Strength	How often?	Why are you taking this medication?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Are you experiencing any of the following symptoms/or having any problems with the following:**

Yes No

Ears, eyes, nose, throat, or neck problems		
Appetite changes/weight loss/gain		
Infection/recent illness		
Breathing or heart problems		
Abdominal pain, bowel changes		
Skin problems, joint or muscle aches		
Memory loss or headaches		
Menstrual periods/female organs/breast problems		
Low energy/fatigue		
Urinary symptoms		
Abnormal bleeding		
Hot flashes/night sweats		
Hair growth		
Pelvic pain with intercourse		
Weight loss/gain		
Chills/fever		
Cold symptoms		

How much do you smoke? \_\_\_\_\_

How much alcohol do you drink? \_\_\_\_\_

Do you use or have you used IV/illegal drugs? \_\_\_\_\_

Which drugs? \_\_\_\_\_

Other information you would like us to know:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Patient Signature: \_\_\_\_\_

Clinical staff initials \_\_\_\_\_ Practitioner initials \_\_\_\_\_

## Women's Health for Life, Inc. Financial Policy

We are committed to providing you with the best possible care. We need your acknowledgement and understanding of our office's financial policy. Please read and initial each section. We do reserve the right to refuse to treat you for unwillingness to sign our financial policy. This document is designed for full disclosure of fees that you may incur while being a patient in our office. A copy will be given to you to keep.

- A- **Valid Insurance** is required to submit your claims for payment. Payment is due at the time of service if you are unable to supply us with your valid insurance card. These visits are not submitted to insurance at a later date. This includes Ohio Medicaid in most cases. You must come prepared with all insurance information. \_\_\_\_\_
- B- **Co-payments** are due at the time of service. If you do not have your copayment with you at the time of service, we reserve the right to reschedule you. **We do charge an additional billing fee of \$10.00** if we must bill you for your copayment. It is your responsibility to know what your copayment is if it is not listed on your insurance card. \_\_\_\_\_
- C- **Deductibles/Co-Insurance**-you will be billed for any amounts over and above your copayment. A reasonable payment plan will be accepted to pay off these remaining balances. Your payment plan cannot exceed 6 months unless other arrangements are made with our office. Once your account becomes delinquent, we do send it to an outside collection agency to collect payment within 90 days of your first notice of delinquency. Should collections or legal action be necessary on your account, we do reserve the right to charge you for any applicable collection fees or legal fees as a result of this process. This amount will not exceed 30% and will only be the cost of the actual fee to collect the debt. \_\_\_\_\_
- D- **Non-Covered Services**- We do our best to make sure you are aware if services will not be covered by your insurance, but sometimes we don't know this. While the filing of insurance claims is a courtesy to you, you are responsible for payment for services rendered to you from the date of service. Please make sure you check with your insurance before having testing done to be sure it is a covered benefit. We do not do retro determination of benefits. All charges are your responsibility from the date services are rendered to you. If your claim is not paid after 90 days, you will be billed and it will be your responsibility to pay. \_\_\_\_\_
- E- **Yearly Exam** – Most insurance companies pay for one annual visit in a 12 month period. This includes prevention services at your family doctor as well as our office. Please let our staff know if you have had a prevention visit this calendar year to avoid duplication of services. Visits outside the frequency limitations on your plan will be your responsibility to pay \_\_\_\_\_ also, if you have a problem addressed at a yearly visit that is outside the scope of a preventive service, this will be billed separately to your insurance. If denied on same date of service or if a copayment applies you will be billed for this. We will provide this service the same day as a courtesy to you; however you will be responsible for payment. \_\_\_\_\_
- F- **Surgeries**- Our billing department will check with your insurance company for coverage on the procedure you are having done. We will estimate how much your responsibility to pay will be. A deposit is required prior to surgery if deductibles are not met, as well as a payment agreement for any remaining patient balance. Checking your benefits does not guarantee payment. You are ultimately responsible for payment. If your insurance company does not pay within a reasonable time, you will be billed for services. Self-pay patients must pay for the procedure in its entirety before it can be done. We do accept cash, check, major credit cards and care credit as forms of payment. \_\_\_\_\_
- G- **Obstetrical Services**- Obstetrical Services- After your first OB education visit, we will contact your insurance company and verify your benefits. Our fee for your maternity care will be billed to your insurance company AFTER your delivery if your plan does global maternity. You will have an estimate for any expected out of pocket costs. This fee includes all of your regularly scheduled prenatal visits, the delivery and your six week postpartum checkup. HOWEVER, ultrasounds, non-stress tests, lab, non-pregnancy related office visits are billed separately and will require separate copayments/deductibles. We will set you up on a payment plan for your estimated out-of-pocket expense. You can pay it all at once or make payments. Any amounts for non-included services will be billed to you separately. We will reimburse you for any over payment that we may have received. You MUST notify our office immediately of any changes in your insurance plan or benefits. We must have satisfactory payments on your account each month or it may impact the practice's ability to continue to provide care for you. Should your plan be a non-global plan we will do our best to split bill your care to maximize your benefits. \_\_\_\_\_
- H- **Broken Appointments**- Our office does charge for any broken appointment. A broken appointment is failure to call to cancel or reschedule at least 4 hours prior to your appointment time if your spot can not be filled. This fee will range from \$20.00 to \$100.00 depending on the type of appointment or procedure. After the third missed appointment you will be dismissed from the practice. \_\_\_\_\_
- I- **Additional fees you should know** Leave of absence forms \$10.00, Return Check fee of \$35.00, Phone consultation without an appointment \$25.00, Work or School Physicals \$40.00, Tax Statement \$10.00, Refill or new prescription outside of an appointment \$10.00, After hours or weekend visits in office are an additional fee of \$75.00, Emergency visits during office hours in the office are an additional fee of \$45.00. Rebilling fee (if applicable) 3% of total patient balance on account after 90 days \_\_\_\_\_

### **AUTHORIZATION AND ASSIGNMENT**

By signing below, I acknowledge acceptance of all of the above terms of payment as outlined in this agreement and initialed by me.

I authorize the release of any medical or other information necessary to process my medical claims as requested by my insurance. I also authorize and request that payment of benefits be made directly to Women’s Health For Life, Inc. I understand that this authorization will remain until I withdraw the authorization in writing. I have read and understand the above Financial Policy and all of my questions have been answered. I understand that changes can be made to this at any time and I will be notified. I understand that this is a legal document and can be submitted in the event of collections. I also understand that payment of all services rendered is ultimately my financial responsibility in all cases and must be paid in a timely fashion. I also understand that diagnosis codes or procedure codes cannot and will not be changed just to receive payment for services rendered. Codes will only be changed in the result of an error by the providers at Women’s Health for Life, Inc. and after complete review by our coding department. By signing this authorization it is a blanket authorization for those reviews of my medical record should they be necessary.

For Questions regarding this notice, please contact:  
Business Office at 419-224-0084

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Patient or Responsible Party (PLEASE PRINT)

Date of Birth

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Signature of Patient/Responsible Party if patient a minor

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Staff Reviewer Signature



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### Patient Notice-Of-Privacy-Policy (To be given to all patients)

#### **What you need to know about the Confidentiality Policy**

Women's Health For Life, Inc. is committed to providing you with high quality health care and to forming a relationship with you that is built on **trust**. That means respecting your **privacy** and **confidentiality** of your medical information. We protect your privacy and confidentiality rights by creating and putting into practice policies and procedures that allow access to your personal medical information **only** for legitimate reasons.

#### **Your medical record**

As we provide your health care, we are required to maintain a complete copy of your medical history, current condition, treatment plan, and all treatment given, including the results of all tests, procedures, and therapies. Whether this information is stored in writing, on a computer, or other means, we will keep this information in a safe and secure way that protects your privacy and confidentiality. Of course, the physicians and other health care professionals who are involved in your care need to access this information in order to provide appropriate treatment for you.

#### **Your medical information is private and confidential**

You, or anyone whom you give written permission, or your legal representatives, have the right to read or get a copy of your medical information. Your medical record is the physical property of Women's Health For Life, Inc.

#### **How do we assure your privacy?**

Women's Health For Life, Inc. has put in place detailed policies regarding access to medical records by our staff and employees and has carefully outlined the circumstances under which your medical information may be released to parties outside Women's Health For Life, Inc. These policies conform with state and federal law and are designed to safeguard your privacy. Our staff and employees are trained in the appropriate use of medical information and know that it is available to them only to continue to provide care to you or for other limited but legitimate reasons. A violation of confidentiality or the failure of an employee to protect your information from accidental or unauthorized access will not be tolerated. This may include the employee being fired from her job.

#### **We ask for your permission**

We do not allow others outside Women's Health For Life, Inc. to access your medical information unless we have the appropriate authorization to do so. We will request your authorization to release information at your first visit. In addition, some laws prevent certain types of patient information from being released without specific patient permission. Examples include, but are not limited to:

- Confidential details of:
  - Psychotherapy (from records of my treatment by a psychiatrist, licensed psychologist, or psychiatric clinical nurse specialist)
  - Other professional services of a licensed psychologist
  - Social Work Counseling/Therapy
  - Domestic Violence Victims' Counseling
  - Sexual Assault Counseling
- HIV test results (Patient authorization required for **EACH** release request.)
- Records pertaining to Sexually-Transmitted Diseases
- Alcohol and Drug Abuse Records

Please note, however, that the law requires some information to be disclosed in certain circumstances. This includes mandatory reports of abuse of children or elderly or disabled persons. Also, subpoenas or court orders may compel the disclosure of confidential or privileged health information in the context of a lawsuit or administrative proceeding. Medical records are sometimes used for reasons other than patient care. For example, records are periodically reviewed to evaluate the quality of care, or to be sure that it follows the rules of regulatory agencies for the efficient and effective utilization of care such as Medicare, Department of Public Health, or Department of Mental Health. Your insurance company may request information that we are required to submit in order to provide and bill for your care. Anyone reviewing records must follow the same confidentiality laws and rules required of all health care providers. Patient records are valuable tools used by researchers in finding the best possible treatments for diseases and medical conditions. All researchers must follow the same rules and laws that other health care workers are required to follow to insure the privacy of patient information. Information that may identify you will not be released to anyone outside Women's Health For Life, Inc. without your written approval. In all research conducted within Women's Health For Life, Inc., concern for your privacy and well-being is our first priority.

**If you have questions** about the privacy of your medical records, please speak with your physician or the office manager, as appropriate. We will be happy to help you.







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PH(419) 227-2727  
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770 W. High St., Suite 400  
Lima, OH 45801  
PH (419)227-2727  
FAX 419-224-1589

## AUTHORIZATION FOR RELEASE AND EXCHANGE OF INFORMATION

FROM: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

To: Women's Health for Life, Inc.  
High Street Location: \_\_\_\_\_  
Bellefontaine Ave Location: \_\_\_\_\_

*This information may include but is not limited to the following please check the lines you would like released:*

Medical Summary Sheet \_\_\_ Office Notes/Progress Notes \_\_\_ Lab and Radiology Results \_\_\_  
Obstetrics Records \_\_\_ Operative Notes \_\_\_ Pathology Results \_\_\_ Surgical Photos \_\_\_ Ultrasound \_\_\_  
Pap Smears \_\_\_ Mammograms \_\_\_ (from the past 5 years) \_\_\_ Immunization or Shot Records \_\_\_  
I consent to HIV, Physical abuse or Mental Health or Alcohol and Drug Records be released: Y \_\_\_ or N \_\_\_  
Additional information requested to be released: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date of Request: \_\_\_\_\_ Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Name used when treatment occurred: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Minor patient: ( ) Yes ( ) NO

Dates (if known) of requested information: \_\_\_\_\_ or ( ) All treatment dates

Reason for Request: ( ) work ( ) Insurance ( ) second Opinion ( ) Transfer of care ( ) Personal  
( ) Other- Please describe: \_\_\_\_\_

I hereby authorize the entity named above to release and/or exchange the above identifying information from my medical records. This release will remain in effect for six months from the date of my signature below unless I revoke this request in writing at any time. This revocation will not apply if the records have already been released to the party listed above. I understand that the office of Women's Health for Life, Inc. will not re-disclose any information contained in this authorization at any point and time with the exception of continuity of care for a condition being co-managed or referrals made from our office.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent or Legal Guardian if Minor Patient

\_\_\_\_\_  
Date

Request records to be sent:  
( ) U.S. Mail ( ) Fax ( ) Electronic \_\_\_\_\_

Released to Physician ( ) or Patient ( )

If we are unable to provide an electronic copy of your medical records a hard copy will be released to you instead via U.S. Mail unless fax is checked above.



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[www.womenshealthforlife.com](http://www.womenshealthforlife.com)

Name (print): \_\_\_\_\_ Date: \_\_\_\_\_

How would you like to receive NORMAL lab/pap/x-ray results?

- E-Mail—E-Mail address: \_\_\_\_\_
- Mail
- Text—Cell phone Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Cell phone carrier: (Circle one)
  - ❖ AT & T [—number@txt.att.com](mailto:—number@txt.att.com)
  - ❖ Verizon [—number@vtext.com](mailto:—number@vtext.com)
  - ❖ Alltel [—number@message.alltel.com](mailto:—number@message.alltel.com)
  - ❖ T-Mobile [—number@tmomail.com](mailto:—number@tmomail.com)
  - ❖ Sprint [—number@messaging.sprintpcs.com](mailto:—number@messaging.sprintpcs.com)
  - ❖ Virgin Mobile [—number@vmobl.com](mailto:—number@vmobl.com)
  - ❖ Boost [—numbr@myboostmobile.com](mailto:—numbr@myboostmobile.com)

New guidelines from the American Medical Association in conjunction with the Center for Disease Control and the Federal Government require physician's office to ask the following information. Certain sub-populations of patients are at risk for certain diseases just because of Ethnicity.

Please complete the following questions:

Language Spoken Primary: \_\_\_\_\_ Secondary: \_\_\_\_\_

Race (check one please):

\_\_\_\_\_ Indian \_\_\_\_\_ Asian \_\_\_\_\_ Hispanic \_\_\_\_\_ African American \_\_\_\_\_ Latino \_\_\_\_\_ White

Ethnicity: Hispanic or Latino \_\_\_\_\_  
Non Hispanic or Non Latino \_\_\_\_\_