



Washington Township Medical Foundation

Part of Washington Hospital Healthcare System

Women's Health Specialists

2299 Mowry Avenue, Ste 3C

Fremont, California 94538

Phone: (510) 796-7057

Fax: (510) 796-5198

Name:	Reason for Visit:	Date of Visit:
Date of Last Pap Smear:	Date of Last Mammogram:	Date of Birth:
Primary MD:	Preferred Pharmacy:	Age:

GYNECOLOGIC HISTORY:

Date of last menstrual period: _____ Unsure Menopausal: Age of Menopause: _____

Age of first period: _____ Number of days between periods: _____ Days of flow/bleeding: _____

Flow (check applicable): Light Medium Heavy Clots Bleeding between periods

Current method of birth control: _____

Have you ever had any of the following:

	Yes	No	Date		Yes	No	Date
Abnormal Pap Smear	<input type="checkbox"/>	<input type="checkbox"/>		Heavy or Irregular Periods	<input type="checkbox"/>	<input type="checkbox"/>	
Cervical Cancer	<input type="checkbox"/>	<input type="checkbox"/>		Ovarian Cancer	<input type="checkbox"/>	<input type="checkbox"/>	
Endometriosis	<input type="checkbox"/>	<input type="checkbox"/>		Pelvic Inflammatory Disease	<input type="checkbox"/>	<input type="checkbox"/>	
Fibroids of the Uterus	<input type="checkbox"/>	<input type="checkbox"/>		Uterine Cancer	<input type="checkbox"/>	<input type="checkbox"/>	
Incontinence of Urine	<input type="checkbox"/>	<input type="checkbox"/>		Sexually Transmitted Infection	<input type="checkbox"/>	<input type="checkbox"/>	
Infertility	<input type="checkbox"/>	<input type="checkbox"/>		Other (please explain below)	<input type="checkbox"/>	<input type="checkbox"/>	

Comments/Treatment: _____

PREGNANCY HISTORY:

Times Pregnant: _____ Term Births: _____ Premature Births: _____ Miscarriages: _____ Abortions: _____ Living Children: _____

No.	Date (mm/dd/yyyy)	Wks Gest	Labor (hours)	Baby's Weight	Gender	Delivery Type (Vag or C/S)	Pain Meds	Complications
1.								
2.								
3.								
4.								
5.								

Comments: _____

MEDICATIONS (All – Including over-the-counter medications or herbal supplements; if needed, attach separate list)

Medication	Dosage	Indication

[TURN OVER]

ALLERGIES

Medication	Reaction

No known drug allergies

MEDICAL HISTORY – Have you **ever** had any of the following?

	Yes	No		Yes	No
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Blood Clots (also known as DVT or PE)	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Intestinal problems	<input type="checkbox"/>	<input type="checkbox"/>
Breast Problems	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>
Colon Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Lung problems	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis/Osteopenia	<input type="checkbox"/>	<input type="checkbox"/>
Gallbladder problems	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>
Gastrointestinal reflux (severe heartburn)	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Other (please explain below)	<input type="checkbox"/>	<input type="checkbox"/>
Comments/Treatment:					

SURGICAL HISTORY

Date	Operation	Indication	Complications

FAMILY HISTORY – Does anyone in your family have:

	Yes	No	Family Member	Yes	No	Family Member
Birth Defects	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Colon Cancer	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
				<input type="checkbox"/>	<input type="checkbox"/>	
Comments:						

SOCIAL HISTORY

Marital Status: Married Single Domestic Partner Divorced Widowed

Number of sexual partners in the last two years: Male: _____ Female: _____

Do you smoke or use tobacco products? Current Past Never

If CURRENT, how much do you smoke per day? _____ If PAST, how many years ago did you quit? _____

Do you exercise regularly? Yes No If YES, how often and what type: _____

Do you drink alcohol? Yes No If YES, how much and how often: _____

Do you use any illicit drugs? Yes No If YES, what type and how often: _____

Patient's Signature: _____ Doctor's Signature: _____



PATIENT REGISTRATION

Today's Date _____ Home Phone # _____ - _____ - _____ Cell Phone # _____ - _____ - _____

Patient's Last Name _____ First _____ Middle Initial _____

SS # _____ - _____ - _____ Date of Birth _____ / _____ / _____ Male or Female Status: S M D W

Home Address _____ Apartment Number _____

City _____ State _____ Zip Code _____ Email address: _____

Occupation _____ Employer Name _____

Employer Address _____ City _____ State _____ Zip Code _____

Work Phone # _____ - _____ - _____ Emergency Contact _____

Emergency Phone # _____ - _____ - _____ Relationship to Patient _____

Referred By _____ Primary Care Physician _____

How did you hear about us? Advertisement Employer Friend/Relative Other: _____

PRIMARY INSURANCE

Subscriber to Insurance: Self Spouse Parent Company

Last Name _____ First _____ Middle _____

Relationship to Patient _____ SS # _____ - _____ - _____ Date of Birth _____

Insurance Name _____ Subscriber ID _____ Group # _____

Insurance Address _____ Phone # _____ - _____ - _____

City _____ State _____ Zip Code _____

SECONDARY INSURANCE

Subscriber to Insurance: Self Spouse Parent Company

Last Name _____ First _____ Middle _____

Relationship to Patient _____ SS # _____ - _____ - _____ Date of Birth _____

Insurance Name _____ Subscriber ID _____ Group # _____

Insurance Address _____ Phone # _____ - _____ - _____

City _____ State _____ Zip Code _____

WORKERS COMPENSATION

Did you report the injury to your Employer? Yes No

Date of Injury _____ / _____ / _____ Time: _____ AM/PM Claim Number _____

Where Injury Occurred _____

Employer Contact _____ Contact Phone # _____ - _____ - _____

Claims Adjuster _____ Phone _____ - _____ - _____ Fax _____ - _____ - _____

Insurance _____ Address _____

City _____ State _____ Zip Code _____

I hereby state that the information I listed above is accurate and complete. I acknowledge that I am responsible for notifying Washington Township Medical Foundation of any changes made to my contact information and/or insurance.

Medication History Consent: I hereby authorize Washington Township Medical Foundation (WTMF) to obtain my prescription/medication history electronically from multiple sources including pharmacies and physicians outside the practice. I authorize WTMF to obtain my prescription/medication history as often as they determine necessary for my proper medical care.

DATE

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

WASHINGTON TOWNSHIP MEDICAL FOUNDATION NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY!

UNDERSTANDING YOUR HEALTH RECORD/INFORMATION;

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information often referred to as your health or medical record, serves as a basis for planning your care and treatment and serves as a means of communication among the many health professionals who contribute to your care. Understanding what is in your record and how your health information is used helps you to ensure it's accuracy, better understand who, what, when, where and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

YOUR HEALTH INFORMATION RIGHTS:

Unless otherwise required by law that your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to request a restriction on certain uses and disclosures of your information, and request amendments to your health record. This includes the right to obtain a paper copy of the notice of information practices upon request, inspect, and obtain a copy of your health record, obtain an accounting of disclosures of your health information, request communications of your health information by alternative means or at alternative locations, and revoke your authorization to use or disclose health information except to the extent that action has already been taken.

OUR RESPONSIBILITIES:

Washington Township Medical Foundation is required to maintain the privacy of your health information. In addition, we are required to provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you. This organization must abide by the terms of this notice, notify you if we are unable to agree to a requested restriction, and accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations. We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us. If we maintain a Web site that provides information about our customer services or benefits, we will post our new notice on that Web site. We will not use or disclose your health information without your authorization, except as described in this notice.

FOR MORE INFORMATION OR TO REPORT A PROBLEM:

If you have questions and would like additional information, you may contact Michelle Smith at (510) 248-1000. If you believe your privacy rights have been violated, you can file a complaint with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

HOW WE WILL USE YOUR HEALTH INFORMATION:

We will use your health information for treatment. For example: Information obtained by a healthcare practitioner will be recorded in your record and used to determine the course of treatment that should work best for you. We will also provide your other practitioners with copies of various reports that should assist them in treating you.

We will use your health information for payment. For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your health information for regular health operations. For example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Business Associates: There may be some services provided in our organization through contracts with Business Associates. Examples include physician services in the Emergency Department and Radiology, or certain laboratory tests. When these services are contracted, we may disclose some or all of your health information to our Business Associate so that they can perform the job we've asked them to do. TO protect your health information, however, we require the Business Associate to appropriately safeguard your information.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with family: Health professionals, using their best judgment, may disclose to a family member, other relatives, close personal friends or any other person you identify, health information relevant to that person's involvement in your care or payment related to care.

Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Food and Drug Administration (FDA): As required by law, we may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs or replacement.

Workers Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public Health: As required by law, we may disclose your health information to public health or legal authorities charged with tracking birth and deaths, as well as with preventing or controlling disease, injury, or disability.

Correctional Institution: Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals. An inmate does not have the right to the Notice of Privacy Practices.

Law Enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena. Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

Notice of Privacy Practices availability: This notice will be prominently posted in the office where registration occurs. Patients will be provided a hard copy and the notice will be maintained on our Website for downloading.

EFFECTIVE DATE: FEBRUARY 1, 2007



NOTICE OF PRIVACY PRACTICES

Acknowledgement of Receipt of Privacy Notice & Consent of Disclosure

(For the Usage and/or Disclosure of Protected Health Information)

By signing this form, you are acknowledging that Washington Township Medical Foundation has given you a copy of our Notice of Privacy Practices, which explains how your health information will be handled in various situations. You also acknowledge that Washington Township Medical Foundation has given you the chance to discuss your questions and concerns about the privacy of your health information. We must try to have you sign this form on your first date of service with us after April 14, 2003. If your first date of service with us was due to an emergency, we must try to give you this notice and get your signature acknowledging receipt of this notice as soon as we can after the emergency.

You are also giving consent to Washington Township Medical Foundation and all health care providers furnishing care with Washington Township Medical Foundation, to use and disclose your protected health information for the purposes of treatment, payment and health care operations. You may cancel this consent at any time. Your cancellation must be in writing, signed by you or on your behalf, and delivered to the address listed below. This may be delivered in person or by mail, but it will only be effective when we actually receive it. Your cancellation will not be effective to the extent that others we have acted in reliance upon this consent.

You have the right to request restriction on the usage and disclosure of your protected health information for the purposes of treatment, payment or health care operations. We are not required to grant your request, however, if we do, the restriction will be obligatory to us. Our posted Notice of Privacy Practices provides more detailed information about the usage and disclosure of your protected health information. You have the right to review our Notice of Privacy Practices before you sign this consent. We reserve the right to amend the terms of our posted Privacy Policy. You may obtain a copy of the current policy by contacting our office at **(510) 248-1000**, or visiting our web site at **www.mywtmf.com**.

Notice to Consumers

Medical doctors are licensed and regulated by the Medical Board of California – (800) 633-2322 • www.mbc.ca.gov.

I understand that the physicians of Washington Township Medical Foundation are licensed and regulated by the Medical Board of California.

Date: _____

Patient Name: _____ Signature: _____

If you are signing as the patient's representative:

Print Your Name: _____ Relationship: _____



**AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION
AS REQUIRED BY HIPAA PRIVACY RULES**

Patient:

Name of Patient _____ Birth Date

Street Address _____ City, State, Zip

Authorizes:

Release Of Protected Health Information To:

Name of Health Care Provider _____ Name of Health Care Provider

Street Address _____ Street Address

City, State, Zip Code _____ City, State, Zip Code

Information To Be Released:

- | | | |
|--|---|--|
| <input type="checkbox"/> Medical History, Examination, Reports | <input type="checkbox"/> Surgical Reports | <input type="checkbox"/> Immunizations |
| <input type="checkbox"/> Treatment or Tests | <input type="checkbox"/> Hospital Records Including Reports | <input type="checkbox"/> X-ray Reports |
| <input type="checkbox"/> Allergy Records | <input type="checkbox"/> Laboratory Reports | <input type="checkbox"/> Prescriptions |
| <input type="checkbox"/> Consultations | <input type="checkbox"/> Entire Record | |
| <input type="checkbox"/> Other (Specify): _____ | | |

Purpose For Need Of Disclosure: (Check applicable categories)

- | | | |
|---|--|-----------------------------------|
| <input type="checkbox"/> Further Medical Care | <input type="checkbox"/> Legal Investigation or Action | <input type="checkbox"/> Personal |
| <input type="checkbox"/> Insurance Eligibility/Benefits | <input type="checkbox"/> Changing Physicians | |
| <input type="checkbox"/> Other (Specify): _____ | | |

I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans or health care clearinghouses, who must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be redisclosed without obtaining my authorization.

Your Rights With Respect To This Authorization:

Right to Inspect or Copy the Health Information to Be Used or Disclosed - I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting the medical records department of the Washington Township Medical Foundation. **Right to Receive Copy of This Authorization** - I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form. **Right to Refuse to Sign This Authorization** - I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. **Right to Withdraw This Authorization** - I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact the medical records department of Washington Township Medical Foundation. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and or organization(s) listed above have already made in reference to this authorization.

Expiration Date: This authorization is good until the following date(s) _____ or for one year from the date signed.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

Signature of Patient or Legal Representative: _____ **Date:** _____
(If signed by other than patient, state relationship and authority to do so.)

Signature of WTMF Representative: _____ **Date:** _____



REQUEST FOR RESTRICTION ON USES AND DISCLOSURES OF HEALTH INFORMATION BY WASHINGTON TOWNSHIP MEDICAL FOUNDATION

Patient Name: _____ Date of Request: _____

Patient Date of Birth: _____

I give permission for Washington Township Medical Foundation to disclose my health information to the following family members, friends or other people involved in my care:

Name: _____ Relationship: _____

a. _____

b. _____

c. _____

d. _____

e. _____

You have the right to ask us to restrict or disclose medical information we make to those family members or others involved in your care or involved in payment for your care or for notification purposes. We are not required to agree to your request. If we do agree, we will put it in writing and will abide by the agreement except when you require emergency treatment. If we do not agree to your request, we will notify you of our decision in writing.

By submitting this form, I hereby request that Washington Township Medical Foundation disclose of patient health information as described above. I understand and acknowledge that the clinic is not required to agree to this request.

Print name of Patient or Representative: _____

Signature of Patient or Representative: _____

FOR MEDICAL STAFF USE ONLY

Date form received: _____ **Staff initials:** _____

I am withdrawing my permission to disclose my health information to the following family members, friends or other people involved in my care:

a. _____ b. _____

c. _____ d. _____

e. _____

Print name of Patient or Representative: _____ Date: _____

Signature of Patient or Representative: _____

FOR MEDICAL STAFF USE ONLY

Date form received: _____ **Staff initials:** _____

FINANCIAL POLICY

PATIENTS WITH INSURANCE:

Although we bill your insurance company/medical group for services rendered, you are financially responsible for all services rendered. If payment has not been received within sixty (60) days of billing your health plan/medical group, we may contact you for assistance. Should your health plan/medical group deny coverage for any reason, you will be responsible for that payment in full within thirty (30) days of receipt of your billing statement. For your convenience, we accept cash, Mastercard, Visa, debit cards, and personal checks.

DUAL COVERAGE:

Washington Township Medical Foundation abides by the California State Insurance Laws, which govern coordination of benefits. Therefore, you are responsible for providing us with all billing information for primary, secondary, and tertiary health plans. Dual coverage does not necessarily ensure that you will not have a co-pay for your office visit. If a co-pay is not collected at the time of your visit and subsequently your insurance plan states that a co-pay is due, you will be responsible for paying that co-pay amount thirty (30) days from the date you receive your billing statement. For your convenience, we accept cash, Mastercard, Visa, debit cards, and personal checks.

PATIENTS WITHOUT INSURANCE:

Our fees cannot always be determined in advance, since they depend on actual services provided. If you would like an estimated total amount before being seen, please ask the front desk personnel. Please note that this is only an estimated amount and the actual charge totals may vary from this estimate. Payment for all services is due at the time of service. For your convenience, we accept cash, Mastercard, Visa, debit cards, and personal checks. As a courtesy, a 55% discount will be applied to office and preventative services, and a 25% discount will be applied to in-office surgical procedures at the time of service.

CO-PAY POLICY:

It is your obligation to be familiar with your insurance co-payment and/or deductible amounts. Your co-pay amount must be paid at the time of your visit.

NO-SHOW POLICY:

Washington Township Medical Foundation requires twenty-four (24) hour notice of cancellation for scheduled appointments. In the event that we are not notified twenty-four (24) hours prior to your appointment, you will be charged a \$25.00 "No-Show" fee.

DELINQUENT ACCOUNTS:

Patient accounts not paid within sixty (60) days of the date of service may be turned over to a collection agency.

RETURNED CHECKS:

There will be a \$25.00 service fee for returned checks.

REFUND POLICY:

If you have been notified by your insurance company that you are due a refund, please contact our office.

FEE FOR COPYING MEDICAL RECORDS:

There is a copying fee of \$15.00 for medical records provided to a patient, insurance company, attorney, etc... However, there is no charge to transfer records to another medical provider upon request.

OTHER FEES:

There is a nominal charge of \$15.00 for each form/report (i.e. DMV forms, school/sport physicals, etc...) that requires completion by the physician. However, this fee is waived if there is a *separate* scheduled appointment for this request.

There is a \$15.00 replacement fee for new copies of any immunization record.

There is a \$15.00 fee for any request for letters written (i.e. Health verification letters to insurances/employers, special circumstance letters, etc...) on your behalf as a patient.

AUTHORIZATION AND ASSIGNMENT OF BENEFITS:

I authorize the release of any medical information, which may have a bearing on the determination, and/or payment of my claim. I request that payment is made directly to Washington Township Medical Foundation and I acknowledge that I am responsible for payment if this assignment is not honored. I understand that I am responsible for all co-payment, co-insurance, and deductible that I may have with my insurance. I further understand that I have been provided a service and it is my responsibility to know my own insurance coverage and be aware of services that may or may not be covered.

I have read and understand the above policies, and I agree to comply with them. I attest that all information is true and accurate to the best of my knowledge.

Patient Signature _____ Date _____

Parent Signature _____ Date _____
(For Minor)