THE Women's Clinic AT THE GROVE

5740 Getwell Road
Building 1, Suite B
Southaven, MS 38672

Phone 662.470.7969
Fax 844.830.7467
info@wcgrove.com

PATIENT INFORMATION

Date _____

Last Name _____ First Name _____ MI _____

DOB _____ Age _____ Marital Status _____ Race _____

Street Address _____ Email _____

City _____ State _____ Zip _____

Social Security Number _____ Contact Phone _____

INSURANCE INFORMATION

Insurance Name _____

Policy Number _____ Group Number _____

Subscriber Name _____ DOB _____

PHARMACY INFORMATION

1. Pharmacy _____ Phone _____

2. Pharmacy _____ Phone _____

EMERGENCY CONTACT INFORMATION

Name of Local Friend or Relative _____

Cell Phone _____ Relation To Patient _____

Do you have a primary care physician that you would like reports sent to? If so, please list their name and phone number:

Name _____ Phone _____

Do you have medical records you would like to have sent to our office? ☐ Yes ☐ No

Name _____ Phone _____

HIPPA FORM

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Name _____ **DOB** _____

May we leave a message at your home? ☐ Yes ☐ No

May we leave a message on your cell? ☐ Yes ☐ No

May we send a yearly recall to your home? ☐ Yes ☐ No

Do we have consent to text your cell? ☐ Yes ☐ No

Do we have consent to email you? ☐ Yes ☐ No

May we leave normal lab results on any of your contact numbers or email addresses? ☐ Yes ☐ No

I acknowledge and agree to adhere to the Notice of Privacy Practices as required by federal and state guidelines. I have been provided a copy of the Notice of Privacy Practice and understand that I may request and review a copy of these Practices at any time from the office staff. I permit the release of any information, including my medical records that may be requested by my insurance company to process any claims.

Patient Signature _____ **Date** _____

PRIVACY MANAGEMENT - PROTECTED HEALTH INFORMATION AND COMMUNICATIONS

I hereby authorize release of my health information (PHI), including account status, test results, scheduled appointments, and information regarding my treatment, to persons I have listed below. Any person who is not listed will not be able to obtain protected health information. It is not necessary to list other treating physicians or insurance companies.

Name of Authorized Person	Relationship	Phone Number
1.		
2.		
3.		
4.		
5.		

CONSENT TO TREAT

- I hereby give my permission to The Women's Clinic At The Grove for medical treatment including but not limited to examination, injections, blood tests, diagnostic testing, or medical procedures deemed necessary and appropriate for diagnosis and treatment.

PAYMENT POLICY

- I understand I am financially responsible for payment of all charges at the time services are rendered including any charges in excess of my insurance as reasonable and customary, whether or not covered by Medicare or other insurance. I understand that I am responsible for verifying my insurance coverage and verifying my benefits with my insurance company.
- It is policy for The Women's Clinic At The Grove to collect all patient balances, co-pays,and deposits due from patients at time of service.
- If you are being seen for certain surgical or medical procedures, our office may contact your insurance carrier to verify insurance coverage and benefits. Your financial responsibility will be determined according to contractual agreement between The Women's Clinic At The Grove and your insurance company for these services.
- If your insurance claim is denied due to incorrect personal information or insurance information that you have provided, you will be billed for any unpaid claims for your services and payment in full will be due immediately.
- If your account or any account for which you are responsible is sent to a collection agency due to non-payment of any patient balance, you may be dismissed from the practice for any future care and services.
- Your health insurance may not provide coverage for all medical services, tests, and/or procedures that our providers may offer or recommend for your treatment. It is your responsibility to know and understand the services covered by your insurance, and if your insurance does not cover these services, you will be responsible for payment.
- You are also responsible for knowing which hospital your insurance carrier allows you to utilize for your procedures, tests and admissions.
- If you do not have medical coverage with an insurance for which The Women's Clinic participates or if you are a new patient and cannot supply your new insurance card or for which coverage cannot be determined, you must pay in full at time of service.
- Certain labs collected in this office may be sent to an outside lab for testing. As such, you may be billed by that reference lab for these.

RETURNED CHECK CHARGE

- The Women's Clinic At The Grove will charge the patient account $25.00 for any returned checks to cover The Women's Clinic's cost for any related bank charges.

WELLNESS/ANNUAL VISITS WITH OTHER PROBLEMS

- If during your annual/wellness exam, you have or need treatment for a problem and the problem is addressed during the visit in lieu of scheduling a separate appointment, in addition to the preventive exam it may be necessary that a problem/E&M visit be billed along with other labs, testing, and/or procedures, which may be subject to copays and/or deductibles.

PRACTICE GUIDELINES

- Routine medication refills are called in only during office hours. We do not refill prescriptions after hours on weekends.
- Requests for narcotic prescriptions will not be granted after hours or on weekends.
- If you have questions for the nurse or provider, we will return your call as soon as possible, giving priority to emergencies and scheduled patients in office.
- Physician excuses for days missed from work or school are written only for the days you are seen in our office and additional days needed for recovery. We are unable to write excuses for illnesses not evaluated in our office. We will not back date excuses.

Signature _____ **Date** _____

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MEDICAL HISTORY

Name _____ **DOB** _____ **Date** _____

Reason For Today's Visit: _____

_____

Current Medications

_____ _____

_____ _____

_____ _____

Past Medical History: Please check any illness or conditions that apply

☐ High Blood Pressure ☐ Acid Reflux/GERD ☐ Irritable Bowl Syndrome

☐ Heart Disease ☐ Celiac or Crohn's Disease ☐ Kidney Disease or Kidney Stones

☐ Heart Murmur ☐ Frequent Urinary Tract Infections ☐ Liver Disease or Hepatitis

☐ High Cholesterol ☐ Diabetes ☐ Asthma or Lung Disease

☐ Blood Clots ☐ Migraine Headaches ☐ Eating Disorder

☐ Osteoporosis or Osteopenia ☐ Thyroid Disease: ☐ Hyperthyroidism ☐ Hypothyroidism

☐ Arthritis: ☐ Osteoarthritis ☐ Rheumatoid Arthritis

☐ Psychological: ☐ Anxiety ☐ Depression ☐ Bipolar ☐ ADD

☐ Cancer: Type _____ Treatment _____

☐ Other: _____

Allergies _____

Gynecological History

First day of your last normal period: _____ ☐ I am no longer having periods

Describe your menstrual periods: ☐ Regular ☐ Irregular Describe: ☐ Light ☐ Medium ☐ Heavy

Do you experience cramps? ☐ Yes ☐ No Describe: ☐ Mild ☐ Moderate ☐ Severe

Are you currently sexually active? ☐ Yes ☐ No Birth control method: _____

Date of last pap smear: _____ Result: _____

History of abnormal pap smear? ☐ Yes ☐ No Details: _____

Date of last mammogram: _____ Result: _____

History of abnormal mammogram? ☐ Yes ☐ No Details: _____

Date of last colonoscopy: _____ ☐ I have never had a colonoscopy

Date of last bone density: _____ ☐ I have never had a bone density

MEDICAL HISTORY . . . *continued*

Obstetrical History

Total Number of Pregnancies _____ Total Number of Living Children _____

Full Term _____ Preterm _____ Elective Abortions _____ Miscarriages _____

List Deliveries:

Date	Wks Delivered	Vag or C/S	Birth Weight	Sex

Surgical History

Date	Type Of Surgery

Recent Hospitalizations

Date	Reason

Family History

Please list any significant family medical history, especially cancer or heart conditions.

Family Member	Alive/Deceased	Age	Health Conditions

Social History

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Engaged

Who do you live with? ☐ Alone ☐ Spouse ☐ Significant Other ☐ Children ☐ Parents ☐ Other _____

Do you smoke? ☐ Yes ☐ No If yes, type and amount per day? _____

Do you drink alcoholic beverages? ☐ Yes ☐ No How many drinks per week? _____

Do you use any type of illicit drugs or substances? ☐ Yes ☐ No Type: _____

Are you currently in a situation or relationship that makes you feel uncomfortable or threatened? ☐ Yes ☐ No

Do you have an advanced directive or living will? ☐ Yes ☐ No

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PRIVACY AGREEMENT

Name _____ **DOB** _____

I have reviewed the NOTICE OF PRIVACY PRACTICE FOR PROTECTED HEALTH INFORMATION (45 CFR 164.520) form provided to me by The Women's Clinic At The Grove, LLC. I have been given the opportunity to ask questions regarding the privacy practices described therein.

I agree to be bound to the terms of this agreement. I also understand that I may revoke the terms of this agreement at anytime if I provide this request in writing. Such revocation will only be effective when this has been received and witnessed in the office. Any future revocation in the agreement will only apply to dealings after receipt. Any changes to this agreement will not apply to previous obligations made under the terms of this agreement.

Patient Signature _____

Printed Name _____

Date _____

Witness Signature _____

Date _____