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Visionary Woman Care

JENNIFER S. HAYES DO, FACOOG
SHARON WELSH, MSN, ARNP

Today's Date: _____

Patient Name: _____ _____ ____
Last First M.I.

Home Address: _____
Street Apt# City State Zip

Birth Date: _____/_____/_____ Age: _____ SS # _____-_____-_____

Home # (_____)_____ Cell # (_____)_____ Work # (_____)_____

E-mail: _____

☐ ***Check if you would like to receive our quarterly health updates.***

Preferred Contact (CIRCLE): Home Work Cell E-mail

Emergency Contact:_____ Phone # (_____) _____

Employer: _____ Occupation: _____

Employer Address:_____ Phone # (_____) _____

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

Spouse Name: _____ Phone # (_____) _____

Date of Birth: _____/_____/_____

Primary Care Physician: _____ Phone # (_____) _____

Pharmacy Name: _____ Phone # (_____) _____

Lab Name: _____ Phone # (_____) _____

Imaging Name: _____ Phone # (_____) _____

HOW DID YOU HEAR ABOUT US?

☐ You've Been a Patient of Dr. Hayes ☐ In-Office – Current Patient/Staff Member _____
☐ Friend / Family Who may we thank?_____
☐ Physician / Healthcare Provider Who may we thank?_____
☐ Internet – Google/Yahoo/OnlineSurgery.com/Other Site: _____
☐ Media / TV / Lecture / Seminar / Print _____
☐ Print Advertising _____

RELEASE OF INFORMATION: *We will only discuss your protected health information (PHI) with you unless you authorize us to discuss it with someone else. Please list below the name(s) of individuals you authorize our office to discuss your care with. If this list changes, please notify us in writing.*

_____ _____

_____ _____

Notice of Privacy Practices: I acknowledge that I have been offered a copy of our "Notice of Privacy Practices" and I have read and understand the above and agree to comply. *(You will be given a copy of Notice of Privacy Practices at your first visit.)*

Patient's Signature: _____ Date: _____/_____/_____

REASON FOR VISIT TODAY

REVIEW OF SYSTEMS

Please check any problems you are currently having.

1. **General:** ☐ fever ☐ chills ☐ weight loss ☐ weight gain ☐ fatigue ☐ insomnia
2. **Eyes, Ear, Nose & Throat:** ☐ vision changes ☐ glasses or contacts ☐ headache ☐ hearing loss ☐ sinusitis
3. **Cardiovascular:** ☐ swelling of legs ☐ chest pain ☐ dizzy spells ☐ fainting ☐ difficulty breathing with exertion ☐ rapid hart beat ☐ irregular heartbeat
4. **Respiratory:** shortness of breath ☐ wheezing ☐ cough ☐ coughing up blood
5. **Gastrointestinal:** ☐ constipation ☐ diarrhea ☐ bloody stool ☐ nausea ☐ vomiting ☐ indigestion ☐ fecal incontinence ☐ flatulence
6. **Genitourinary:** ☐ burning with urination ☐ night time urination ☐ frequent urination ☐ trouble emptying your bladder leaking urine ☐ blood in urine ☐ infertility
7. **Musculoskeletal:** ☐ muscle weakness ☐ muscle pain ☐ joint pain ☐ back pain
8. **Skin:** ☐ dry ☐ rash ☐ itch ☐ ulcers ☐ pigmented lesions ☐ change in moles
9. **Breasts:** ☐ pain ☐ lump ☐ nipple discharge
10. **Neurologic:** ☐ fainting ☐ seizures ☐ numbness ☐ severe memory problems ☐ migraine ☐ headaches ☐ trouble walking ☐ ringing in ears
11. **Psychiatric:** ☐ anxiety ☐ depression ☐ crying spells ☐ mood swings
12. **Endocrine:** ☐ hair loss ☐ heat or cold intolerance ☐ excessive sweating ☐ excessive thirst
13. **Hematologic:** ☐ bleeding ☐ bruising ☐ swollen lymph nodes

PERSONAL PAST HISTORY

☐ Anemia	☐ Diets	☐ Lupus
☐ Arthritis	☐ Eating Disorder	☐ Mitral Valve Prolapse
☐ Asthma	☐ Fibroids	☐ Obesity
☐ Blood Clots (legs/Lungs)	☐ Heart Disease	☐ Osteoporosis
☐ Blood Transfusions	☐ Heart Murmur	☐ Pneumonia
☐ Bowel Problems	☐ Hepatitis	☐ Reflux
☐ Broken Bones	☐ Herpes or Genital Warts	☐ Rheumatic Fever
☐ Cancer (location _____)	☐ HIV (known exposure)	☐ Seizures
☐ Chicken Pox	☐ High Blood Pressure	☐ Stroke
☐ Chlamydia or Gonorrhea	☐ High Cholesterol	☐ Syphilis
☐ Depression	☐ Infertility	☐ Thyroid Disease
☐ Diabetes	☐ Kidney Stones	☐ Tuberculosis

SURGICAL HISTORY

List all Surgeries: _____

_____

List all Hospitalizations: _____

_____

HEALTH

Screenings	Date of last Pap? _____ Last mammogram? _____ Last bone density? _____
	Have you ever had abnormal Pap? ☐ yes ☐ no Last Colonsocopy? _____
	_____
Exercise	☐ Sedentary (no exercise)
	☐ Mild exercise (i.e., climb stairs, walk 3 block, golf)
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 min.)
Diet	Are you dieting? ☐ yes ☐ no Describe _____
	Are you on a physician prescribed medical diet? ☐ yes ☐ no Which one? _____
	# of meals you eat in an average day? _____ Glasses of water per day?_____
Caffeine	☐ None ☐ Coffee ☐ Tea ☐ Soda ☐ None ☐ Energy Drink
	# of cups or cans a day? _____
Alcohol	Do you drink alcohol? ☐ yes ☐ no
	# of glasses/cans per week? _____
Tobacco	Do you use tobacco? ☐ yes ☐ no # cigarettes per day? _____ # of years? _____
	or # of years quit? _____
Drugs	Do you currently use recreational or street drugs? ☐ yes ☐ no
Vital Stats	Height _____ Current Weight _____ Maximum Weight _____

List your current **Prescription Medications, Herbs, Vitamins**, appetite suppressants, over-the-counter meds

Name the Drug	Strength	Frequency Taken

List all **Allergies:** _____

_____

_____

FAMILY HISTORY

Does anyone in your family have any of the following (check and list relative)

- ☐ Arthritis (Lupus) _____
- ☐ Blood Clots _____
- ☐ Breast Cancer _____
- ☐ Colon Cancer _____
- ☐ Diabetes _____
- ☐ Heart Disease _____
- ☐ High Blood Pressure _____
- ☐ Ovarian Cancer _____
- ☐ Kidney Disease _____
- ☐ Osteoporosis _____
- ☐ Seizures _____
- ☐ Stroke _____
- ☐ Uterine Cancer _____

Mother: Age _____ If deceased, cause of death and age _____

Father: Age _____ If deceased, cause of death and age _____

OBSTETRICAL HISTORY

List ALL births, ectopics, miscarriages and terminations:

_____

_____

_____

Birth Year	Birth Weight	Baby's Sex	Type of Delivery	Complications

UROGYN HISTORY

Age at onset of menstruation? _____ First day of last menses? _____

Heavy periods, irregularity, spotting, pain, or discharge? _____

Period every_____days? Length of periods? _____

Any changes in your period? _____

Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?

☐ yes ☐ no _____

Are you currently sexually active? ☐ yes ☐ no ☐ Men ☐ Women ☐ Both

Libido issues? _____

What type of contraception are you using? _____ # of lifetime sexual partners? _____

Any hot flashes or sweating at night? ☐ yes ☐ no Insomnia? ☐ yes ☐ no

Any Hair loss? ☐ yes ☐ no Energy/Vitality issues? ☐ yes ☐ no

Experienced any recent breast tenderness, lumps, or nipple discharge? ☐ yes ☐ no

Any problems with control of urination? ☐ yes ☐ no _____

Any discomfort or loss of sensation with intercourse? ☐ yes ☐ no _____

Any vaginal dryness, discharge, irritation or odor? ☐ yes ☐ no _____

Ever have kidney infection? ☐ yes ☐ no

Bladder infection? ☐ yes ☐ no

INSURANCE INFORMATION:

Primary Insurance Company Name: _____

Address: _____ Phone: (_____) _____

Insured Name: _____ Employer: _____

Date of Birth: _____ Social Security Number: _____

Policy Number: _____ Group Number: _____

Co-pay Amount: $_____ or Yearly Deductible: $_____

Secondary Insurance Company Name:

Address: _____ Phone: (_____) _____

Insured Name: _____ Employer: _____

Policy Number: _____ Group Number: _____

Date of Birth: _____ Social Security Number: _____

Co-pay Amount: $_____ or Yearly Deductible: $_____

Payment/Insurance Authorization and Assignment:

For situations in which I can use my insurance for payment, I hereby authorize Visionary Woman Care to furnish all information to insurance carriers concerning my illness, and/or treatments, and I hereby assign to the physician all payments for medical services rendered to myself or my dependents.

I understand that I am responsible for any amount not covered by insurance; this includes any course of treatment that is not a covered benefit (this includes HMO products). I understand that I am responsible for notifying Visionary Centre for Women of any changes in my insurance coverage. If I am delinquent in updating this information and the charges are denied, I understand that I will be responsible for these charges.

Patient Name: (please print) _____

Patient's Signature: _____ Date: _____/_____/_____ __

FINANCIAL POLICY

Welcome to our practice. We strive to provide you with excellent medical care and our goal is to make your visits as comfortable as possible.

1. **Insurance.** We participate in most insurance plans, including Medicare. If you are not insured, or not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. **Co-payments and deductibles.** All co-payments must be paid before or at the time of service. All deductibles must be paid when the amount is known. This arrangement is part of your contract with your insurance company. This fee is your responsibility. We cannot guarantee the deductible amount since it varies among patients and their plans and what services have been accessed in the recent past. It is best to call your insurance company.

3. **Non-covered services.** Please be aware that some-and perhaps all-of the services you receive may be non-covered, considered investigational by some health plans, or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

4. **Proof of insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. **Claims submission.** As a courtesy to you, we will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract. It is your responsibility to ask your plan what is covered and what is not covered.

6. **Coverage.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 90 days, the balance will automatically be billed to you.

7. **Nonpayment.** If your account is over 90 days past due, you will receive a letter stating that you have 30 days to pay your account in full. Partial payments will not be accepted unless prior arrangements have been made. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During the 30 day period, our physician will only be able to treat you on an emergency basis.

8. **Recurrent missed appointments.** We may charge a $25 fee for recurrent missed appointments not canceled within 24 hrs. These charges will be your responsibility.

9. **Bounced checks.** Please be advised there is a $50 fee for any bounced or returned checks.

10. **Paperwork.** There is a $25 fee for our office to fill out paperwork (FMLA).

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines.

Signature of patient or responsible party_____Date_____

Print Name_____

PATIENT RIGHTS & RESPONSIBILITIES

You Have The Right:

- To be treated with respect, consideration and dignity, without discrimination on the basis of race, color, sex, religion, or national origin.
- To know the policy on rights and responsibilities you have as a patient.
- To participate in decisions involving your health care; to be assisted in the development of advance directives, and to know and take responsibility for the consequences of refusing treatment or not complying with therapy.
- To receive services in a safe and clean environment.
- To privacy and confidentiality and to approve or refuse the release of your medical records, except when release is required.
- To receive information concerning your diagnosis, treatments, and prognosis; and to accept or refuse treatment after full information is given.
- To know what provisions are available for after hours and emergency coverage; and to have access to an interpreter as needed in order to understand explanations.
- To know the fees for services provided and the policies regarding the payment of fees.
- To be free from abuse or neglect; to access protective services.
- To be referred to specialists and other professionals when needed and to change physicians if you are not satisfied and if other qualified physicians are available.
- To voice a compliment or complaint by calling (727) 540-0414 or fax: (727) 540-0672 or e-mail: drjenniferhayes@gmail.com

You Have The Responsibility:

- To provide, to the best of your knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to your health.
- To follow the treatment plan recommended by the practitioner responsible for your care; and for your actions if you refuse treatment or do not follow the practitioner's instructions.
- To keep appointments and, when unable to do so for any reason, to notify our office within 24 hrs.
- To ensure that the financial obligations of your health care are fulfilled as promptly as possible.
- To be considerate of the rights of other patients and personnel.
- To be respectful of the property of others.
- To ask for clarification when explanations regarding your treatment have not been given to your satisfaction.

ABOUT ADVANCE DIRECTIVES

Upon registration, we will ask you if you have an advance directive. An advance directive is a written document which communicates your health care wishes clearly.

There are two types of advance directives:

A Durable Power of Attorney for Health Care - is a document that allows you to designate another person (known as a proxy agent) who is at least 18 years of age to make medical decisions for you in the event you are unable to do so. These decisions may include, but are not limited to, the withholding or withdrawal of life prolonging procedures.

A Living Will or Health Care Directive - is a document that allows you to state in advance your wishes regarding the use of certain medical procedures and treatments and becomes effective when you are unable to make your own decisions and can no longer communicate such decisions. It serves as a guide to your family or the person you name as your agent.

Name of Patient	Signature of Patient	Date Time
Name of Legal Authorized Person	Signature of Legal Authorized Person	Date Time
Name of Witness	Signature of Witness	Date Time