Camelback Women's Health

Authorization to Share Protected Information

Camelback Women's Health **DOES NOT** release private health information to anyone without specific written authorization to do so.

Protection of confidential information also applies to spouses, partners, and parents (including parents of minors in certain circumstances) in accordance with state and federal laws.

Please mark one:

_____ **I do not wish to have my personal and confidential information shared with anyone other than myself.**

_____ I am giving Camelback Women's Health permission to share my personal, protected and confidential information with the individuals I have listed below. I understand this authorizes complete access to the following protected information including, but not limited to: laboratory results, radiology results, physician notes, assessments, findings, and opinions, as well as, financial information relating to account status, collection status, and payment history:

Name: _____ Relationship: _____ SS# or DOB _____

Name: _____ Relationship: _____ SS# or DOB _____

Name: _____ Relationship: _____ SS# or DOB _____

Name: _____ Relationship: _____ SS# or DOB _____

This authorization will remain in effect ***indefinitely*** unless a specific date is written here: _____

I understand this authorization may be revoked or revised at any time by me in writing. I understand Camelback Women's Health cannot be held responsible for information released under this agreement prior to the receipt of a written revocation and I will not hold Camelback Women's Health responsible for such disclosures.

I understand I will need to provide separate written authorization to receive copies of my protected health information. Photocopying fees will apply unless records are sent directly to another physician.

I have read this agreement and understand my personal protected health information **will not** be shared unless I have specifically indicated the approved individuals above.

_____

Patient Name

_____ _____

Patient Signature Date

Camelback Women's Health

PATIENT INFORMATION

Patient Name: Last, First, MI			Maiden Name:	Date of Birth:
Address:	City:	State:	Zip:	Social Security #:
Home Phone: ( )	Work Phone & Ext. ( )		Cell Phone: ( )	
E-mail Address:			Marital Status: S M D W	
Occupation:	Employer Name:			
Contact Preference: ____Home ____Work ____Cell ____E-mail	**Race (optional):** ___African American ___Asian ___ Asian Indian ___Native American ___ Pacific Islander ___ White		**Ethnicity (optional):** ___ Hispanic/Latino ___ Not Hispanic/Latino	

Spouse/ Significant Other or Parent Name: Last, First, MI		Date of Birth:
Work Phone & Ext. ( )	Cell Phone: ( )	
Occupation:	Employer Name:	

Emergency Contact: (Other than spouse/significant other)		Relationship:
Home Phone: ( )	Work Phone & Ext. ( )	Cell Phone: ( )

Primary Care Physician:	Phone Number:
Preferred Pharmacy:	Phone Number & Location:

How were you referred to Camelback Women's Health? _____ Social Media _____ Advertisement _____ Internet Search _____ Friend/Family Member _____ Primary Care Physician _____ Insurance Booklet _____ Please Explain:

My **PRIMARY** insurance policy is through: ****THE EMPLOYEE IS CONSIDERED THE POLICY HOLDER***

____ My Employer ____ Spouse's Employer _____ Mother's Employer _____ Father's Employer ____ State/Federal

Insurance Company Name:	Policy Holder Name:		Policy Holder DOB:
ID #:	Group #:	Social Security # of policy holder:	
Claims Address:	City:	State:	Zip:
Insurance Phone: ( )	Relationship to Policy Holder:		

My **SECONDARY** insurance policy is through: ****THE EMPLOYEE IS CONSIDERED THE POLICY HOLDER***

____ My Employer ____ Spouse's Employer ____ Mother's Employer ____ Father's Employer ____ State/Federal

Insurance Company Name:	Policy Holder Name:		Policy Holder DOB:
ID #:	Group #:	Social Security # of policy holder:	
Claims Address:	City:	State:	Zip:
Insurance Phone: ( )	Relationship to Policy Holder:		

I certify the above information is correct and understand I am required to provide a photo ID for the protection of my personal information:

Patient Signature: _____ Date:_____

Parent/Guardian Signature: _____

Camelback
Women's Health

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used, disclosed, and how you can get access to your information.

Your Rights:

You have the right to:

- Get a copy of your medical record upon written request. Photocopy fee will apply.
- Request reasonable corrections be made to your medical record.
- Request how we communicate with you.
- Ask us to limit the information we share with others.
- Get a list of those with whom we've shared your information.
- Obtain a copy of this privacy notice.
- Choose someone to act on your behalf.
- File a complaint if you believe your privacy rights have been violated.

Your Choices:

You have some choices in the way that we use and share information as we:

- Discuss your condition with family or friends.
- Provide disaster relief recovery information.
- Include you in a hospital directory.
- Provide mental health care services.
- Market our services to you.

Our Uses & Disclosures:

We may use and share your information as we:

- Provide medical treatment for you.
- Run our organization.
- Bill your insurance for payment.
- Assist with public health/safety issues.
- Do research.
- Comply with state and federal law.
- Respond to organ and tissue donation requests.
- Work with medical examiner or funeral director.
- Address worker's compensation, law enforcement, or government requests.
- Respond to lawsuits and legal action.

Our Responsibilities:

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and provide you a copy.
- We will not use or share your information other than as described here unless you tell us we can in writing

For detailed information regarding this policy, please visit our website at *www.camelbackwomenshealth.com*. We can change the terms of this notice, and the changes will apply to all information we have about you. A new notice will be available upon request, in our office, and on our web site.

Privacy Officer for Camelback Women's Health:
Laura Sue Fein; Practice Manager
11209 N Tatum Blvd, Suite 255
Phoenix, AZ 85028
602-494-5050

I have read the above and understand my rights, my choices, and the responsibilities of Camelback Women's Health in regards to my protected health information.

_____

Printed Name of Patient

_____ _____

Signature of Patient/Guardian Date

Camelback Women's Health

PATIENT FINANCIAL RESPONSIBILITY AGREEMENT

Thank you for choosing Camelback Women's Health ("CWH") as your healthcare provider!

The medical services you seek here imply an obligation on your part to ensure payment in full is made for services you receive. This **Patient Financial Responsibility Agreement** will assist you in understanding that financial responsibility.

Consent. I consent to treatment and services ordered by my Physician or Nurse Practitioner at CWH and/or its associates. I understand my healthcare provider may perform medically necessary services, as well as 'elective' services, according to current standard of care guidelines. I do have the right to consider or decline services prior to them being performed. My consent to undergo such treatment and/or services will be considered a non-verbal agreement to pay for the services provided to me.

Responsibility. I understand I am ultimately responsible for all payment obligations arising out of my treatment and care and I guarantee payment for these services. I am responsible for deductibles, co-payments, co-insurance or any other patient responsibility amounts indicated by my insurance carrier or for any services not covered by my insurance.

Insurance Policy. It is my responsibility for knowing and understanding my insurance policy, both the coverage benefits and policy limitations. I understand I am personally responsible for payment when: (i) my health plan requires prior authorization/referral by a primary care physician (PCP) before receiving services, and I have not obtained such an authorization or referral; (ii) I receive services in excess of the authorization/referral; (iii) my health plan determines the services I received are not medically necessary and/or not covered by my insurance plan; (iv) my coverage has lapsed/expired at the time services are rendered; (v) I have chosen to utilize my out-of-network benefits; or (vi) I have chosen not to use my health plan coverage for services I receive.

Payment Arrangements. Whether or not I have insurance or are self-pay, payment of my account balance is due within thirty (30) days of receipt of my billing statement. I understand if I need to make special payment arrangements, I may contact the Patient Accounts Staff to arrange a mutually agreeable payment plan. I agree to make monthly payments on this plan until my account is paid in full. If my account is over ninety (90) days past due, my account will be in default and may be referred to a collection agency.

Payments Accepted. I understand I can make payments by check, cash, money order, debit cards or credit cards (Visa, MasterCard, American Express or Discover), or via PayPal.

Payment by Check. If my check payment is returned or declined for any reason, my account will be charged a surcharge of $35.00 in addition to any costs assessed or charged by the bank. Checks returned to the office are also subject to further collections by the **Maricopa County Attorney**'s office unless a valid method of payment is forwarded upon request. After two (2) returned checks have been received by CWH, my personal checks will no longer be accepted and I will be responsible for using another method of payment.

Ancillary Services. I may receive ancillary medical services while a patient of CWH such as anesthesia; interpretation of tests; imaging services (e.g., ultrasound and mammogram); diagnostic testing, etc. I understand some physicians may not provide services directly in my presence, but are actively involved in the course of my diagnosis and treatment. I authorize payment directly for these services under the policy issued to me by my insurance carrier. I may incur additional charges as a result of ancillary services. I agree to pay all remaining charges for services after benefits paid on my behalf are credited to my account as determined by my insurance carrier.

Collection of Anticipated Charges. For maternity care/services, office and surgical procedures, CWH will collect my anticipated financial responsibility for such services prior to delivery for prenatal care; and prior to delivery or prior to scheduling an office or surgical procedure. CWH will contact my insurance carrier to determine an estimate of the anticipated amounts owed based on the current contracted amounts and fee schedules. I will not hold CWH responsibility for incorrect/inaccurate information provided by my insurance carrier regarding my insurance benefits or benefit plans. CWH does not accept responsibility for incorrect information given by me or my insurance carrier regarding my insurance benefits or benefit plans. If an account balance remains due after the claim has been processed and amounts collected for anticipated charges have been applied, I understand I will be held responsible for the remaining amount and am ultimately responsible for payment

Non-Payment on Account. Should collection proceedings or other legal action become necessary to collect my overdue or delinquent account, I understand CWH has the right to disclose to an outside collection agency or attorney all relevant personal and account information necessary to collect payment for services rendered. I am responsible for all costs of collection including, but not limited to: (i) late fees and charges and interest due as a result of such delinquency; (ii) a $50.00 collection agency fee will be added to outstanding balances placed with a collection agency; (iii) Interest of 10% per year will be accrued on the principal balance placed with the agency; (ii) all attorney/court costs and fees incurred in the collection process; and I acknowledge that if my account is referred to a collection agency, legal representative, court, or when the past due status is reported to a credit reporting agency, it may have an adverse effect on my credit history. Once my account is placed with a credit/collection agency, I am responsible for communicating with their offices for payment. I may lose my ability to be seen at CWH as a result of my account being sent to a collections agency.

Minor Patients. The patient/guardian presenting with a minor for care is the responsible party for payment of the minor's account balance regardless of the responsibility judgment between parents. CWH will not act as administrator to resolve my financial agreements. According to state law and in certain situations, a minor can seek and will be provided treatment in CWH offices without parental consent or knowledge. Minors can choose to utilize their insurance coverage provided by their parent for claims submission or they can choose to be self-pay. Depending on the circumstances of the visit, CWH may or may not share information upon parental request. State law allows minors the right to patient confidentiality under certain circumstances.

Authorization to Contact. I authorize CWH personnel to communicate with me by mail, answering machine messages, and/or e-mail according to the information provided in my patient registration information and my patient portal setting preferences. CWH, or any agent or servicer of my patient account, may use any information I have provided, including contact information, e-mail addresses, cell phone numbers, and landline numbers, to contact me for purposes related to my health and my account, including debt collection. I authorize CWH to use this information in any manner consistent with the information I have provided, including mail, telephone calls, e-mails, or text messages. I expressly consent to any such contact being made by the most efficient technology available, including automatic dialing/e-mailing or similar equipment, or pre-recorded or other messages.

Acknowledgement. I understand I am ultimately responsible for payment for the services I receive at CWH, regardless of my health insurance coverage. I understand CWH will not act as administrator to resolve my personal financial agreements in regards to my medical care. I have had the opportunity to read this financial statement in its entirety and have had the opportunity to ask questions regarding the details of this statement. Any questions have been answered to my satisfaction.

I consent to and agree to the aforementioned policies of Camelback Women's Health's and understand they may be changed without notice.

_____ _____

Patient Name Date

_____

Signature

Please refer to our website at www.camelbackwomenshealth.com for additional information regarding our financial policies.

Rev. 11/2017

Camelback Women's Health

Patient Health History Questionnaire

Patient Name:	Date of Birth:

What is the reason you're being seen today?

PAST SURGERIES

Type: _____ Date: _____ Where: _____

Type: _____ Date: _____ Where: _____

Type: _____ Date: _____ Where: _____

Type: _____ Date: _____ Where: _____

CURRENT MEDICATIONS

Name: _____ Mgs/units: _____ How often? _____

Name: _____ Mgs/units: _____ How often? _____

Name: _____ Mgs/units: _____ How often? _____

Name: _____ Mgs/units: _____ How often? _____

MEDICATION ALLERGIES

If none write 'NONE' here: _____

Name: _____ Type of reaction: _____

Name: _____ Type of reaction: _____

Name: _____ Type of reaction: _____

PAST MEDICAL HISTORY

	No	Yes	Please explain, if yes:
Anemia			
Bladder			
Bleeding/Clotting			
Blood Disorder			
Bowel			
Cancer			
Depression			
Diabetes			
Fibromyalgia			
Headaches			
Hearing Problems			
Heart			
Hemorrhoids			
Hernia			
Kidney			
Liver/Hepatitis			
Mental Illness			

Neurological			
Osteoporosis			
Past Auto Accident			
Respiratory/Lung			
Seasonal Allergies			
Seizures			
STD's			
Skin			
Stomach/Intestines			
Thyroid			
Ulcers			
Vision			
OTHER:			

SOCIAL HISTORY

Marital Status	___Single ___Married ___Domestic Partner ___Divorced ___Separated ___Widowed
Sexually Active	___ Yes ___ No
Sexual Orientation	___Heterosexual ____Homosexual ___Bisexual
History of infertility?	___Yes ___No
Education Level	___ Elementary ___ High School __ Some College ___College Graduate __ Post Grad
Current Occupation	
Stress Level	___ Low ___Moderate ___High
Exercise Level	___None ___Occasional ___Moderate ___High
Diet	___Regular ___ Vegetarian ___ Vegan ___ Special (describe):
Caffeine Intake	___None ___Occasional ___ Moderate ___ Heavy
Smoking Status	___Never ___ Former ___ Current: How often? Years?
Alcohol Intake	___None ___ Occasional ____ Moderate ____ Heavy How long?
Illicit Drug Use	___Never ___ Former ___Current: Type: How often?
Are there cats in your home?	___Yes ___ No
Exposure to chemicals or radiation?	___Yes ___ No
History of a LEEP/cone biopsy?	___Yes ___No If yes, when:
Do you routinely use seatbelts?	___Yes ___ No
Do you routinely use sunscreen?	___Yes ___ No
Is a blood transfusion acceptable in an emergency?	___Yes ___ No
Are you of Jewish ancestry?	___Yes ___ No
Are you of African American ancestry?	___Yes ___ No

FAMILY HISTORY

Relationship	Health Problem	Onset Age	Age of Death
	___ Thyroid ___ Allergies ___ High Blood Pressure ___ Diabetes ___ Epilepsy ___ Stroke ___ Heart Disease ___ Mental Illness ___ Blood Disease ___ High Cholesterol ___ Cancer: Type:____________________________________ __ Other:		
	___ Thyroid ___ Allergies ___ High Blood Pressure ___ Diabetes ___ Epilepsy ___ Stroke ___ Heart Disease ___ Mental Illness ___ Blood Disease ___ High Cholesterol ___ Cancer: Type:____________________________________ __ Other:		
	___ Thyroid ___ Allergies ___ High Blood Pressure ___ Diabetes ___ Epilepsy ___ Stroke ___ Heart Disease ___ Mental Illness ___ Blood Disease ___ High Cholesterol ___ Cancer: Type:____________________________________ __ Other:		

	___ Thyroid ___ Allergies ___ High Blood Pressure ___ Diabetes ___ Epilepsy ___ Stroke ___ Heart Disease ___ Mental Illness ___ Blood Disease ___ High Cholesterol ___ Cancer: Type:___________________________________ __ Other:		

GYNECOLOGICAL HISTORY

Date of last period?	Approximate? Definite?
How long does your period last?	
How many days between periods?	
How is the flow?	___Light ____ Moderate ___Heavy
Do you experience clotting?	___ Yes ___ No
Are your periods painful?	Never Rare Occasionally Always
Age you began having periods?	
Do you have a history of abnormal paps?	
Were you treated for abnormal paps?	
Have you been treated for STD's?	
Are you currently sexually active?	
What are you using for birth control?	
Date of last mammogram	
Date of last pap smear	
Date of last bone mineral density screen	
Date of last cholesterol screen?	
Have you received the Gardasil injection?	
Age at first pregnancy?	
Planning future pregnancies?	
If menopausal, what age did it begin?	

OBSTETRIC HISTORY

Date of Delivery	Outcome?	Length Labor	Weight	Sex	Delivery Type	Problems/Complications
	___ Full term ___ Stillborn ___ Premature ___ Miscarriage ___ Termination			M F	__Vaginal __ C/Section	
	___ Full term ___ Stillborn ___ Premature ___ Miscarriage ___ Termination			M F	__Vaginal __ C/Section	
	___ Full term ___ Stillborn ___ Premature ___ Miscarriage ___ Termination			M F	__Vaginal __ C/Section	
	___ Full term ___ Stillborn ___ Premature ___ Miscarriage ___ Termination			M F	__Vaginal __ C/Section	
	___ Full term ___ Stillborn ___ Premature ___ Miscarriage ___ Termination			M F	__Vaginal __ C/Section	

I certify that the above is true and correct to the best of my knowledge:

____

Patient Name

____ ____

Patient Signature Date