WINCHESTER WOMEN'S
SPECIALISTS, P.C.

1870 Amherst St., Suite 2E
Winchester, VA 22601
Tel (540) 667-4546 • Fax (540) 667-6893

John H. Lowder, Jr., M.D.
Mark T. Leonard, M.D.
James K. Nashed, M.D.
George F. Craft II, M.D.

Obstetrics • Gynecology • Infertility
Mammagraphy & Laser Surgery
Colposcopy & Hysteroscopy
Diagnostic Lboratory

PATIENT REGISTRATION FORM

Date:________________ **Doctor:**____________ **Chart#:**____________

Patient Name:________________________ **Home Phone#( )**____________
(Legal First) MI Last

P.O. Box:________________________ **Work Phone # ( )**________ **Ext**____

Street Address:________________________ **Cell Phone#( )**____________

City:________________ **State:**____ **Zip:**______ **Date of Birth:**________ **Age**______

Patient Employer:________________________ **Patient Occupation:**____________

Employer Address:________________________ **Martial Status:**____________

Social Security#:____________ **Referring MD.:**________ **Family M.D.**__________

Maiden Name:________________________ **Last Menstrual Period:**____________

Medication Allergies? Yes ____ **No** ____ **Hysterectomy: Yes**___ **No**___ **Date:** ______

If Yes, What?____________________________________

Preferred Pharmacy________________ ____________ ____ ____
(not mail-in) **Name** **City** **State** **ZIP**

Emergency Contact:________________________ **Phone#:**____________

Relationship to Patient:________________________

Spouse's Name:________________________ **Spouse's SS#:** ____________
Spouse's DOB:____________

Spouse's Employer:____________________________________

Spouse's Employer's Address:________________________________

INSURANCE INFORMATION:

Primary Ins. Co:________________ **Name of Insured:**____________

Group#________ **ID#**__________ **Date of Birth of Insured:** ____________

2nd INS CO:________________ **Name of Insured:**____________

Group#________ **ID#**__________ **Date of Birth of Insured:**____________

PLEASE GIVE RECEPTIONIST A COPY OF YOUR INS. CARD

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540-667-4546

GYNECOLOGIC INTAKE HISTORY

NAME:______________________ BIRTH DATE:___/___/___ DATE:___/___/___

ADDRESS:______________________

CITY______________________ STATE/ZIP:______________________

HOME TEL:( )______________________ WORK TEL:( )______________________

EMPLOYER:______________________ INSURANCE:______________________

NAME OF SPOUSE/PARTNER:______________________ REFERRED BY:______________________

REVIEW OF SYSTEMS

PLEASE CHECK (X) IF ANY OF THE FOLLOWING APPLY TO YOU NOW, IN THE PAST OR OFTEN

1. CONSTITUTIONAL	CURRENTLY	PAST	NOTES
Weight loss	☐	☐	
Weight gain	☐	☐	
Fever	☐	☐	
Fatigue	☐	☐	
2. EYES			
Double vision	☐	☐	
Spots before eyes	☐	☐	
Vision changes	☐	☐	
3. ENT/MOUTH			
Ear aches	☐	☐	
Ringing in ears	☐	☐	
Sinus problems	☐	☐	
Sore throat	☐	☐	
Mouth sores	☐	☐	
Dental problems	☐	☐	
4. CARDIOVASCULAR			
Painful breathing	☐	☐	
Chest pain	☐	☐	
Difficult breathing on exertion	☐	☐	
Swelling of legs	☐	☐	
Palpitations of heart	☐	☐	
5. RESPIRATORY			
Wheezing	☐	☐	
Spitting up blood	☐	☐	
Shortness of breath	☐	☐	
Cough, chronic	☐	☐	
6. GASTROINTESTINAL			
Diarrhea, frequent	☐	☐	
Bloody stool	☐	☐	
Nausea/vomiting	☐	☐	
Constipation	☐	☐	
7. GENITOURINARY			
Blood in urine	☐	☐	
Pain with urination	☐	☐	
Urgency	☐	☐	
Frequency of urination	☐	☐	
Incomplete emptying	☐	☐	
Stress incontinence	☐	☐	
Abnormal periods	☐	☐	
Painful intercourse	☐	☐	
8. MUSCULOSKELETAL			
Muscle weakness	☐	☐	

PLEASE CHECK (X) IF ANY OF THE FOLLOWING APPLY TO YOU NOW, IN THE PAST OR OFTEN			
9. SKIN/BREAST	**CURRENTLY**	**PAST**	**NOTES**
Pain in breast	☐	☐	
Discharge	☐	☐	
Masses	☐	☐	
Rash	☐	☐	
Ulcers	☐	☐	
10. NEUROLOGICAL			
Dizziness	☐	☐	
Seizures	☐	☐	
Numbness	☐	☐	
Trouble walking	☐	☐	
11. PSYCHIATRIC			
Depression	☐	☐	
Crying, frequent	☐	☐	
12. ENDOCRINE			
Dry skin	☐	☐	
Abnormal thirst	☐	☐	
Hot flashes	☐	☐	
13. HEMATOLOGIC/LYMPHATIC			
Bruises, frequent	☐	☐	
Cuts do not stop bleeding	☐	☐	
Enlarged lymph nodes	☐	☐	
14. ALLERGIC/IMMUNOLOGIC			
Allergies	☐	☐	
Drugs, other	☐	☐	

PERSONAL PAST HISTORY

MAJOR ILLNESSES	YES	NO		YES	NO
Asthma			Cancer		
Pneumonia			Ulcers		
Chronic Lung Disease			Depression/anxiety		
Kidney Infections/stones			Anemia/Blood transfusions		
Tuberculosis			Seizures/convulsions/epilepsy		
Venereal Disease			Bowel trouble		
Heart Trouble/murmur			Glaucoma		
Diabetes			Arthritis/joint pain		
High Blood Pressure			Fracture		
Stroke			Hepatitis/Yellow jaundice		
Rheumatic Fever			Thyroid Disease		

OPERATIONS/HOSPITALIZATIONS

Reason	Date	Reason	Date

INJURIES/ILLNESSES

Type	Date	Type	Date

LAST IMMUNIZATION OR TEST

	Date		Date
Tetanus		Pneumonia	
Flu Shot		TB Skin Test	

OB/GYN HISTORY

	Number		Number
Births		Abortions	
Miscarriages		Living children	

CURRENT MEDICATIONS

Drug Name	Dosage	Drug Name	Dosage

FAMILY HISTORY

illness	Yes	Relative	Illness	Yes	Relative
Diabetes			Drinking Problem		
Stroke			Breast Cancer		
Heart Disease			Colon Cancer		
High Blood Pressure			Ovarian Cancer		

SOCIAL HISTORY

Habits						
Smoking	Yes	☐	No	☐	Packs per day______	Years__________
Alcohol	Yes	☐	No	☐	Drinks per day______	Drinks per week_____
Drug Use	Yes	☐	No	☐		
Seat Belt Use	Yes	☐	No	☐		
Regular Exercise	Yes	☐	No	☐		
Personal Profile						
Marital Status	Married ☐		Single ☐		Widowed ☐	Divorced ☐
Number of Living Children______________						
Number of people in household___________						
School Completed	High School ☐		College ☐		Graduate Degree ☐	Other ☐
Current or most recent job______________________________________						

Completed by: Patient ☐ Office Nurse ☐ Physician ☐

Signature of patient:____

Date reviewed by physician with patient:________________________________

Physician Signature:____

Annual Review of History

Date reviewed:_________________________ Physician Signature:_________________________

Date reviewed:_________________________ Physician Signature:_________________________

Date reviewed:_________________________ Physician Signature:_________________________

Date reviewed:_________________________ Physician Signature:_________________________

WINCHESTER WOMENS' SPECIALISTS, P.C.
HIPPA PRIVACY AND PATIENT RIGHTS
NOTICE
EFFECTIVE APRIL 14, 2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION MAY BE USED AND DISCLOSED
PLEASE READ IT CARFEULLY

INTRODUCTION

We are required by law to maintain the privacy of health and medical information which includes any identifiable information that we obtain from you or others that relates to your physical or mental health, the health care you have received, or payment for your healthcare.

This notice provides you with information about your rights and our legal responsibilities and privacy practices. This notice also discusses the uses and disclosures we will make of your protected health information. We must comply with the provisions of this notice, although we reserve the right to change the terms from time to time. The patient can always request a copy of our most current privacy notice from our office.

Permitted uses and disclosures

We can use or disclose your health information for purposes of treatment, payment and healthcare operations.

Treatment means coordination or management of your healthcare, including consultations between health care providers regarding your treatment and referrals from one healthcare provider to another.

Payment means activities we undertake to obtain reimbursement for the healthcare provided to you, including determinations of edibility, coverage and recertification's, authorization activities. We may bill the carrier or other third party payor for the services rendered to you and can provide the carrier or other third party payor with information regarding your care if necessary.

Health care operations means the support functions of our practice related to treatment and payment, such as quality assurance activities, case management, receiving and responding to patient complaints, compliance programs, physicians reviews, audits, business planning, development and administrative activities.

Disclosures related to communicating with you or family members

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 or relate specifically to your medical care through our office.

We may disclose your information to your family or friends or any other individual identified by you when they are involved in your care or the payment. We may also use or disclose your medical information to notify, assist in the notification of a family member, a personal representative, or another person responsible for your care of your location, general condition or death. If you are available, we will give you an opportunity to object to these disclosures and we will not make these disclosures if you object. If you are not available or in a life threatening situation, we will determine whether a disclosure to your family or friends is in your best interest and will only disclose information that is directly relevant to their involvement in your care.

We will allow your family and friends to act on your behalf to pick up prescriptions, medical supplies, x-rays and similar forms of medication information, when in our professional judgment, that it is in your best interest to make such a decision

Other Situations

Military and Veterans

If you are a member of the armed forces, we may release medical information about you as require by military command authorities. We may also release medical information about foreign military personnel to the appropriate authority.

Workers Compensation

We may release medical information about you for programs that provide benefits for work related injuries or illness.

Public Health Risks

We may release information if:

- It should prevent or control disease, injury or disability
- It will report births and deaths
- We should report victim of abuse, neglect or domestic violence
- We should report adverse reactions to medications
- We should notify people of product, recalls, repairs or replacements
- We need to notify a person who may have been exposed to a disease or at risk for contracting or spreading a disease or condition

Health Oversight Activities

Medical information may be discussed with federal or state agencies that oversee our activities. These activities are necessary for the government to monitor the healthcare system, government programs, and compliance with civil rights laws. We may disclose protected health information to persons under the Food and Drug Administration's jurisdiction to tract products or to conduct post – marketing surveillance.

Law Enforcement

We may release medical information if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant summons or similar process
- To identify or locate a suspect, fugitive, material witness, or missing person
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement.

- About a death we believe may be the result of criminal conduct
- About criminal conduct on or premises
- In emergency circumstances to report a crime, the location of the crime or victims or victims or the identity, description or location of the person who committed the crime

Coroners, Medical Examiners and Funeral Directors

We may release medical information to a coroner or medical examiner.

Inmates

If you are an inmate of a correctional institution or under the custody of a law enforcement official we may release medical information to the correctional institution or law enforcement official.

Serious Threats

As permitted by applicable law and standards of ethical conduct, we may use and disclose protected health information if we, in good faith, believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public

Disaster Relief

When permitted by law, we may coordinate our uses and disclosures of medical information with public or private entities authorized by law or by charter to assist in disaster relief efforts.

YOUR RIGHTS

1. You have the right to request restrictions on our uses and disclosures of medical information for treatment, payment and healthcare operations. However, we are not required to agree to your request.
2. You have the right to reasonably request to receive communications of medical information by alternative means or at alternative locations.
3. Subject to payment of a copying charge as provided by state law, you have the right to inspect or obtain a copy of the medical information contained in your medical and billing records and in any other practice records used by us to make decisions about you, except for:
   - Psychotherapy notes
   - Information compiled in a reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding
   - Information involving laboratory tests when your access is required by law
   - If you are a prison inmate and obtaining such information would jeopardize your health, safety, security, custody or rehabilitation or that of other inmates, or the safety of any officer, employee, or other person at the correctional institution or rehabilitation r that of another inmates, or the safety of any officer, employee, or other person at the correctional institution or person responsible for transporting you.
   - Your protected health information is contained in records kept by a federal agency or contractor when your access is requested by law
   - If the information was obtained from someone other than us under a promise of confidentiality and the access requested would be likely to reveal the source of the information

We may deny a request for access if:

- A licensed professional has determined, in the exercise of professional judgment that the access requested is reasonably likely to endanger your life or physical safety or that of another person
- The information makes reference to another person (unless such other person is a healthcare provider) and a licensed health care professional has determined, in exercise of profession judgment, that the access requested is reasonably to cause substantial harm to such other person
- The request for access is made by the individuals personal representative and a licensed healthcare professional has determined, in the exercise in the professional judgment that the provision of access to such representative is reasonably likely to cause substantial harm to you or another person.

If we deny a request for access for any of the three reasons described as above, then you have the right to have our denial reviewed in accordance with the requirements of applicable law.

You have the right to request a correction to your records, but we may deny your request for corrections, if we determine that the information or record that is the subject of the request was not created by us, is not part of your medical or billing records, is not available for inspections as set forth above and is accurate and complete.

In any event, any agreed upon correction will be included as an addition to, and not a replacement of, already existing records.

You have the right to request and receive a paper copy of this notice from us.

COMPLAINTS

If you believe that your privacy rights have been violated, you should immediately contact our Privacy Officer named below. All complaints must be submitted in writing. We will not take actions against you for filing a complaint.

Office Manager
Winchester Womens' Specialists, P.C.
1870 Amherst Street, Suite 2E
Winchester, VA 22601
Phone: 540-667-4546

WINCHESTER WOMEN'S SPECIALISTS

FINANCIAL POLICY
2011

Thank you for choosing our Practice as your healthcare provider. We are committed to providing you with the highest quality of care. You should understand that timely payment of any bills is necessary. **Please review and sign below.**

- All co-pays and deductibles are due at the time of service. If you are uninsured, we expect full payment at the time of service. Payment plan options should be discussed with us prior to the date of service.

- We will ask that you update your individual information each time you are in the office so that we can ensure timely correct billing. Your signature below indicates your willingness for us to communicate with your insurance carrier for the purposes of verifying benefits and submitting insurance billing.

- If your insurance terminates while we are providing care, you will be responsible for all bills.

- We require that you give us 24 hour notice of appointment cancellation, or accept that we will charge you for a repeated history of missed appointments.

- Services performed outside of the practice are billed separately by the provider of these services. These services may include: certain lab testing, hospital facility charges, and mammography readings. We use BioReference Laboratory for lab tests we do not do here, who will send you a separate bill as necessary.

- There is a charge of $20 per disability form and/or FMLA form completed by our office. Payment is due when you give us the form. You should expect five (5) working days for completion of these forms.

- Our rates and services are usual and customary for our geographic area. We accept cash, personal checks, VISA, MASTERCARD and DISCOVER. There is a $50.00 fee for returned checks.

- Failure to pay your bill in a timely manner will result in our terminating our physician/patient relationship and we may transfer your account to an outside collection firm. Should we have to proceed with collection efforts, you will be responsible for any costs charged to us by our collection agents, attorneys and the Virginia Court System.

I have read this Financial Policy and agree to these terms.

PATIENT SIGNATURE ____________________ DATE ____________________

PRINT NAME ____________________

GUARDIAN SIGNATURE ____________________ DATE ____________________