NEW PATIENT INFORMATION PACKET

We’re here for a healthy you.

DR. GRAYSON
WOODS GYNECOLOGY
FOR A HEALTHY YOU

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PATIENT REGISTRATION FORM

Date _____

Patient Information:

First Name _____ Last Name _____ Mi _____

Preferred Name _____

Social Security _____

Address: _____

City: _____ State: _____ Zip: _____

Preferred Phone _____ Work Phone _____

Cell Phone _____

Date of Birth: _____ -_____ - _____ Age _____

Marital Status: (circle) Single Married Widowed Divorced Separated

If patient is under the age of 18, Name of guarantor _____

Email Address _____

Patient Employer Information:

Employed: Y or N _____ Full-Time Student _____ Part- Time Student _____

Employer Name _____ Occupation _____

Scheduled Working Hours _____

Insurance Information: (must be present at time of service)

Primary Insurance _____

Policy Holder: (must be filled out if other than patient)

Subscriber Name _____

Address (if different than patient) _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Date of Birth: _____ -_____ - _____ Sex: (circle) Female Male Relationship _____

Referred By:

Referring Physician _____ Phone _____

Other _____

Emergency Contact:

Relative/Friend _____ Phone _____

Relationship _____

Pharmacy Information:

Pharmacy Name _____ Phone _____

I authorize the viewing of my prescription drug history from my insurance database.

(circle): yes / no

Signature _____

Methods of Contact:

☐ Text messages are sent 3 days prior to your appointment. If you choose this method, please confirm your appointment with this message. Please list your mobile number.

_____

☐ Phone calls are made 3 days prior to your appointment. If you choose this method, please confirm your appointment with this call. Please list your phone number(s).

_____

Print Patient Name _____

Date _____ Signature _____

SIGNATURE FORM

Financial Responsibility and Release of Information

I understand that I am financially responsible to Woods Gynecology P.C. for charges not covered by my insurance carrier. Payment for services is due at the time of service unless prior arrangements have been made. I also agree that, should I fail to assume this financial responsibility and credit action is necessary, I will pay for these costs in addition to the amount of these physician's charges.

I authorize Woods Gynecology P.C. to release to the Social Security Administration or its intermediaries or carriers, or other insurance carriers any medical or other information needed for this or related insurance claim. A copy of this authorization may be used in place of the original.

Date _____ Signature of Patient or Guardian_____

* I have received a copy of the "Notice of Privacy Practices" for the office of Woods Gynecology P.C.

Please Initial _____

Medicare Extended Payment Request (One Time Authorization) (Medicare Patients Only)

I request the payment of authorized Medicare benefits or other insurance benefits be made on my behalf to Woods Gynecology P.C. for any services furnished me by that provider. This one time signature will be maintained on file as verification for all subsequent services, which are provided to you by this provider. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents or other insurance carriers for any information needed to determine these benefits or the benefits payable for related services.

Date _____ Signature of Patient or Guardian_____

Medigap Authorization (Medicare Patients Only)

I request that payment of authorized Medigap benefits be made on my behalf to Woods Gynecology P.C. (your secondary coverage) for any services furnished me by that provider. I authorize any holder of medical information about me to release to _____ any information needed to determine these benefits (name of 2nd insurance)

Medicare Number:_____ Policy # _____

Secondary Insurance:_____ Date: _____

Signature of Patient or Guardian _____

PAYMENT AND COLLECTION POLICY

Insurance and Payment

We participate with several healthcare plans. Please call our office for special questions regarding your plan and if we participate. You will be required to pay your co-payment or deductible at the time of your visit. We accept cash, money order, debit card, Visa or MasterCard (we do not accept personal checks). If you do not have health care coverage, you're expected to pay in full at the time of service or have made arrangements with us prior to your appointment. Also, it is the patient's responsibility to have any prior authorization or referral before your scheduled appointment. Failure to have a referral prior to service will result in reduced or denied benefits by your managed care plan. Therefore, the patient is responsible for any balances not covered.

As a courtesy to our patients, we will file your insurance. In all cases, the patient is ultimately responsible for all payments. If your insurance refuses payment for any services, you are required to pay our office and negotiate with your insurance company for any payments they have refused.

DELINQUENT ACCOUNTS: We review past due accounts frequently and at every statement cycle. Your communication and involvement to ensure your balance is paid timely is important to us. It is imperative that you maintain communications and fulfill your financial agreement and arrangements to keep your account active and in good standing.

If your account becomes sixty (60) days past due, further steps to collect this debt may be taken. If you fail to pay on time and we refer your account(s) to a third party for collection, a collection fee will be assessed and will be due at the time of the referral to the third party. The fee will be calculated at the maximum percentage permitted by applicable law, not to exceed 18 percent. In addition, we reserve the right to deny future non-emergency treatment for any and all debtor-related unpaid account balances.

CONSENT TO CONTACT: I grant permission and consent to AdvancedHEALTH and its agents, assignees, and contractors (which may include third party debt collectors for past due obligations): (1) to contact me by phone at any number associated with me, if provided by me or another person on my behalf; (2) to leave messages for me and include in any such messages amounts owed by me; (3) to send me text message or emails using any email address I provided or any phone number associated with me, if provided by me or another person on my behalf; and (4) to use prerecorded/artificial voice messages and/or an automated telephone dialing system (an auto dialer) as defined by the Telephone Consumer Protection Act in connection with any communications made to me as provided herein or any related scheduled services and my account. I understand that my refusal to provide the consent described in this paragraph will not affect, directly or indirectly, my right to receive healthcare services.

Missed or No-show Appointment Charge

Our offices requires 48-hour notice of cancellation. If proper notice is not given, we charge a $50 fee to your account.

Forms and Letters

Our office requires a minimum of 7 days to complete disability forms or letters required by the patient's employer or insurance for maternity leave or surgery. There's also a $10 fee for all paperwork to be filled out, and must be paid when forms are dropped off to be completed.

Patient Signature: _____ Date: _____

HEALTH HISTORY

Name _____ Age _____

Reason for visit _____

_____

_____

_____

_____

_____

_____

List all prior surgeries_____

_____

_____

_____

_____

Current medications_____

_____

_____

_____

_____

Medication allergies _____

_____

_____

_____

_____

Phone: 615-630-6969
Fax: 615-630-6968
doctorwoods.com

4322 Harding Pike
Suite 329
Nashville, TN 37205

HEALTH HISTORY

Date of last mammogram _____ Date of last pap _____

Any prior procedures on the breast? _____

History of abnormal paps? _____ Date of last bone density _____

Any prior procedures on the cervix? _____ Date of last colonoscopy _____

Menstrual History:

Age when first period started _____ Number of days between periods _____

Flow (circle): light / medium / heavy Number of days bleeding _____

Pain with periods (circle): yes / no First day of last menstrual period _____

Pregnancy History:

No. of pregnancies _____ No. of living children _____

No. of miscarriages _____ No. of abortions _____

Contraception History: What types of contraception have you used to date?

Current _____

Previous _____

Sexual History:

Have you ever been sexually active? yes no

Are you currently sexually active? yes no

Have you ever had any sexually transmitted diseases? yes no

If yes, which? (circle) Gonorrhea Chlamydia Genital warts Genital herpes Syphilis HIV HPV Hepatitis

HEALTH HISTORY

Social History:

Marital status _____ Name of Spouse / significant other _____

Your current occupation _____

Do you exercise regularly? yes no If yes, list type and frequency _____

Do you smoke or use tobacco products? yes no If yes, list amount used

And type _____ Number of years of use _____

If previously used tobacco products, list the year you quit _____

Do you drink alcohol? yes no If yes, list the number of drinks per week _____

Do you use recreational drugs? yes no If yes, list the type _____

Check if you have a personal or family history of the following. _____

	You	Your Family		You	Your Family
Addiction	☐	☐	High Cholesterol	☐	☐
Anemia	☐	☐	Kidney Disease	☐	☐
Breast/Ovarian Cancer	☐	☐	Kidney Infections	☐	☐
Cirrhosis/Liver Disease	☐	☐	Kidney Stones	☐	☐
Colon/Pancreatic Cancer	☐	☐	Lupus/MS	☐	☐
Depression/Anxiety	☐	☐	Osteoporosis	☐	☐
Diabetes	☐	☐	Seizures/Epilepsy	☐	☐
DVT/Pulmonary Embolus	☐	☐	Stroke	☐	☐
Endometriosis	☐	☐	Thyroid Problems	☐	☐
GI problems/Reflux/IBS	☐	☐	Transfusions	☐	☐
Headaches	☐	☐	Ulcerative Colitis/Crohn's	☐	☐
Heart Disease	☐	☐	Other	☐	☐
High Blood Pressure	☐	☐			

Woods Gynecology, PC - Notice of Privacy Practices

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.

We are required by law to maintain the privacy of your protected health information, to notify you of our legal duties and privacy practices with respect to your health information, and to notify affected individuals following a breach of unsecured health information. This Notice summarizes our duties and your rights concerning your information. Our duties and your rights are set forth more fully in 45 CFR Part 164. We are required to abide by the terms of our Notice that is currently in effect.

1. Uses And Disclosures We May Make Without Written Authorization. We may use or disclose your health information for certain purposes without your written authorization, including the following: Treatment. We may use or disclose your information for purposes of treating you. For example, we may disclose your information to another health care provider so they may treat you; to provide appointment reminders; or to provide information about treatment alternatives or services we offer. Payment. We may use or disclose your information to obtain payment for services provided to you. For example, we may disclose information to your health insurance company or other payer to obtain payment for treatment. Healthcare Operations. We may use or disclose your information for certain activities that are necessary to operate our practice and ensure that our patients receive quality care. For example, we may use information to train or review the performance of our staff or make decisions affecting the practice. Other Uses or Disclosures. We may also use or disclose your information for certain other purposes allowed by 45 CFR § 164.512 or other applicable laws and regulations, including the following: • To avoid a serious threat to your health or safety or the health or safety of others. • As required by state or federal law such as reporting abuse, neglect or certain other events. • As allowed by workers compensation laws for use in workers compensation proceedings. • For certain public health activities such as reporting certain diseases. • For certain public health oversight activities such as audits, investigations, or licensure actions. • In response to a court order, warrant or subpoena in judicial or administrative proceedings. • For certain specialized government functions such as the military or correctional institutions. • For research purposes if certain conditions are satisfied. • In response to certain requests by law enforcement to locate a fugitive, victim or witness, or to report deaths or certain crimes. • To coroners, funeral directors, or organ procurement organizations as necessary to allow them to carry out their duties.

2. Disclosures We May Make Unless You Object. Unless you instruct us otherwise, we may disclose your information as described below. • To a member of your family, relative, friend, or other person who is involved in your healthcare or payment for your healthcare. We will limit the disclosure to the information relevant to that person's involvement in your healthcare or payment. NOTICE OF PRIVACY PRACTICES - 2

3. Uses and Disclosures With Your Written Authorization. Other uses and disclosures not described in this Notice will be made only with your written authorization, including most uses or disclosures of psychotherapy notes; for most marketing purposes. You may revoke your authorization by submitting a written notice to the Privacy Contact identified below. The revocation will not be effective to the extent we have already taken action in reliance on the authorization.

4. Your Rights Concerning Your Protected Health Information. You have the following rights concerning your health information. To exercise any of these rights, you must submit a written request to the Privacy Officer identified below. • You may request additional restrictions on the use or disclosure of information for treatment, payment or healthcare operations. We are not required to agree to the requested restriction except in the limited situation in which you or someone on your behalf pays for an item or service, and you request that information concerning such item or service not be disclosed to a health insurer. • We normally contact you by telephone, mail at your home address and possibly by e-mail if you have given your e-mail address. You may request that we contact you by alternative means or

at alternative locations. We will accommodate reasonable requests. • You may inspect and obtain a copy of records that are used to make decisions about your care or payment for your care, including an electronic copy. We may charge you a reasonable cost-based fee for providing the records. We may deny your request under limited circumstances, e.g., if we determine that disclosure may result in harm to you or others. • You may request that your protected health information be amended. We may deny your request for certain reasons, e.g., if we did not create the record of if we determine that the record is accurate and complete. • You may receive an accounting of certain disclosures we have made of your protected health information. You may receive the first accounting within a 12-month period free of charge. We may charge a reasonable cost-based fee for all subsequent requests during that 12-month period. • You may obtain a paper copy of this Notice upon request. You have this right even if you have agreed to receive the Notice electronically.

5. Changes To This Notice. We reserve the right to change the terms of this Notice at anytime, and to make the new Notice effective for all protected health information that we maintain. If we materially change our privacy practices, we will post a copy of the current Notice in our reception area and on our website. You may obtain a copy of the operative Notice from our receptionist or Privacy Officer.

6. Complaints. You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint with us by notifying our Office Manager. All complaints must be in writing. We will not retaliate against you for filing a complaint.

7. Contact Information. If you have any questions about this Notice, or if you want to object to or complain about any use or disclosure or exercise any right as explained above, please contact:

Office Manager:
Kim Hughes
4322 Harding Pike, Suite 329
Nashville TN 37205
kim@doctorwoods.com

8. Effective Date. This Notice is effective May 7, 2015.