COMPLETE WOMEN'S CARE
A Division of Mid-Atlantic Women's Care, P.L.C.
Board Certified Obstetricians and Gynecologists

Patient Release of Information

Dear Patient,

The Privacy Act of 1977 was designed to protect private information such as medical and financial information. The Privacy Rule was updated in 2003 and is now called Protected Health Information. PHI is any information about health status, provision of health care, or payment of healthcare that can be linked to an individual. This includes any part of a patient's medical record or payment history. In order for Complete Women's Care to release any information to another party other than the patient, we must have signed release of information specifying what information to give and to whom. This includes your spouse, family members, friends, and employer, even in an emergency. If you wish Complete Women's Care to be able to release information to individuals, with your permission, please indicate below.

I, _____, give the staff of Complete Women's Care permission to discuss the following information to the designated individuals.

Name	Relationship	Type of Information (circle)
_____	_____	Medical and/or Financial
_____	_____	Medical and/or Financial
_____	_____	Medical and/or Financial

In an event of an emergency, please contact:

Name _____ Relationship_____

Home Phone _____ Work Phone_____ Cell Phone_____

_____ _____

Patient Signature Date

We ask that you update this information annually, or as circumstances change.
Thank you, Complete Women's Care

Updated _____ _____ _____

Initials/Date Initials/Date Initials/Date

1080 First Colonial Road, Suite 300, Virginia Beach, VA 23454
2075 Glenn Mitchell Drive, Suite 410, Virginia Beach, VA 23456
Phone (757) 481-7222 Fax (757) 481-7045

COMPLETE WOMEN'S CARE
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Financial Policy – Updated August 1, 2016

Thank you for choosing us as your health care provider. We appreciate your trust in us and the opportunity to serve you. The following information is provided to our patients to make our financial policies clear.

INSURANCE COVERAGE

While we make a good faith attempt to verify coverage, we are not able to guarantee that the information given to us by your insurance company is correct. It is your responsibility to know what services may or may not be covered by your insurance. We encourage you to refer to your benefits manual if you have any questions about covered services or direct your questions to your insurance company's member services department. Their number is usually found in the back of your insurance card. You will be responsible for payment of all non-covered services at the time they are rendered. We do require payment of any co-pays and deductibles at check-in.

PRIVATE PAY PATIENTS

Payment for office visits is due at the time of service. A payment plan is available for obstetrical care and for surgical procedures. Please ask to speak with our Financial Counselor for details.

TRICARE PATIENTS

Complete Women's Care is a non-participating provider with Tricare. As a courtesy, we will file your claim with Tricare once payment is received in full from you.

LAB FEES

Please be aware that lab fees for blood work and pathology (including PAP smears) are separate from our office charges and may be billed directly to you by the lab company.

ASSIGNMENT OF BENEFITS / RELEASE OF MEDICAL RECORDS

I have read, understand and agree to the terms of this policy. I authorize release of my medical records to my insurance company to aid in the payment of my insurance claim. I authorize payment of medical benefits to Complete Women's Care. I understand that I am responsible for all charges not covered by insurance, deductibles, co-pays and co-insurance amounts. *I further agree that I will be responsible for interest on any unpaid balance at the rate of eighteen percent (18%) per annum. I agree to pay for all collection and / or attorney's fees up to thirty five percent (35%) of the unpaid balance, plus all costs of collection in the event I default on my payment obligation.*

Printed Name _____ Signature _____ Date _____

COMPLETE WOMEN'S CARE

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Acknowledgement of Receipt of Privacy Notice

By signing below, I am acknowledging that I have been provided with a copy of my Mid-Atlantic Women's Care Privacy Notice pursuant to the Federal regulations known as the HIPPA Privacy Rule.

Patient Name {Please Print}	Your Signature	Date

1080 FIRST COLONIAL ROAD, SUITE 300, VIRGINIA BEACH, VA 23454
2075 GLENN MITCHELL DRIVE, SUITE 410, VIRGINIA BEACH, VA 23456
(757) 481-7222 FAX (757)481-7045
www.CompleteWomensCare.net

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PATIENT NAME _____ **DATE** _____

DATE OF BIRTH: _____ **PRIMARY CARE MD** _____

PHARMACY NAME _____ **LOCATION** _____ **PHONE** _____

E-MAIL ADDRESS _____

This part of the medical record is strictly confidential. It will not be released to any other person or entity without your written authorization.

1. PAST MEDICAL HISTORY

if positive results, please indicate below.

- ☐ Abnormal pap smear
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood clots
- ☐ Breast mass
- ☐ COPD;emphysema;chronic bronchitis
- ☐ Depression or anxiety
- ☐ Diabetes
- ☐ Endometriosis
- ☐ Fibroids of the uterus
- ☐ Genital herpes
- ☐ History of alcoholism
- ☐ OTHER:

- ☐ History of bleeding problems
- ☐ History of blood transfusion
- ☐ History of cancer
- ☐ History of chemotherapy
- ☐ History drug abuse
- ☐ History of fracture
- ☐ History of kidney disease
- ☐ History of radiation treatment
- ☐ History of STD's
- ☐ Migranes
- ☐ Heart disease
- ☐ Hepatitis
- ☐ High cholesterol

- ☐ Hypertension
- ☐ Infertility
- ☐ Irritable bowel syndrome
- ☐ Mental disorder
- ☐ Obstructive sleep apnea
- ☐ Osteoporosis
- ☐ Stomach Ulcer
- ☐ Physical or sexual abuse
- ☐ Seizures
- ☐ Sickle cell anemia
- ☐ Skin disorder
- ☐ Stroke
- ☐ Thyroid disorder

2. PAST SURGICAL HISTORY

☐ No Surgeries

- ☐ Anesthesia complications
- ☐ Appendix removal
- ☐ Breast biopsy
- ☐ C-section
- ☐ Cholecystectomy (Gall bladder)
- ☐ Cosmetic surgery
- ☐ D&C
- ☐ Endometrial ablation

- ☐ Hysterectomy
- ☐ LEEP/Laser/Cryo of cervix
- ☐ Ovary removal
- ☐ Orthopedic surgery _(kind)_____
- ☐ Tonsils
- ☐ Tubal ligation
- ☐ Other: _____

3. MEDICATIONS

☐ NONE

Please list all and provide dosage if know

Name	Dosage	# per Day	Taking long term?

4. ALLERGIES

Please list reactions

Patient Name _____

- ☐ Adhesive tape
- ☐ Aspirin
- ☐ Cephalosporins
- ☐ Cipro
- ☐ Codeine
- ☐ Demerol
- ☐ Erythromycin
- ☐ Ibuprofen
- ☐ Iodine
- ☐ Latex
- ☐ Macrobid
- ☐ Morphine
- ☐ Neosporin
- ☐ Oxycontin
- ☐ Penicillin
- ☐ Quinolones
- ☐ Shellfish (shrimp, lobster, crab, crayfish)
- ☐ Sulfa
- ☐ Tetracyclines
- ☐ Other _____
- ☐ Other _____
- ☐ Other _____
- ☐ Other _____

Details of Allergy:

_____

_____

_____

_____

_____

_____

_____

_____

☐ No known Drug Allergies

5. FAMILY HISTORY

	Family Member Affected	Age of Onset
☐ Blood clotting problems		
☐ Breast cancer		
☐ Colon cancer		
☐ Diabetes		
☐ Genetic diseases		
☐ Heart attack		
☐ High Blood Pressure		
☐ Osteoporosis		
☐ Ovarian cancer		
☐ Stroke		
☐ High Cholesterol		
☐		

☐ Other: (details) _____

Please answer all questions:

Age of first period?	_____		
Are your cycles regular?		yes	no
What is the length of your cycles?	_____	days	
Do you have problems with your cycle?		yes	no
Do you have problems with contraception?		yes	no
Age of menopause?	_____		

6. CONTRACEPTION

Last Menstrual Period _____

Contraception _____

7. PREGNANCY HISTORY

☐ NONE

Please fill out as completely as possible

	Number	Year(s)
☐ Miscarriages		
☐ Abortions		

Patient Name

DELIVERIES

	MM/DD/YR	SEX	VAGINAL	C/SECTION	COMPLICATIONS
1					
2					
3					
4					

8. SOCIAL HISTORY

- ☐ Alcohol use
- ☐ Accepts Blood Product
- ☐ Cigarettes - Current Smoker
- ☐ Cigarettes - Former Smoker
- ☐ No Cigarettes
- ☐ Drugs
- ☐ Education - advanced degree
- ☐ Education - college graduate
- ☐ Education - high school grad
- ☐ Education - some college
- ☐ Education - some high school
- ☐ Education - technical school
- ☐ Exercise - none
- ☐ Exercise - occasional
- ☐ Exercise - regular
- ☐ Marital status - separated
- ☐ Marital status - single
- ☐ Marital status - widowed
- ☐ Marital status - divorced
- ☐ Marital status - married
- ☐ Same Sex Partnership
- ☐ Safety concerns at home
- ☐ Vaccination for Hepatitis B (Date) _____
- ☐ Vaccination for Tetanus (Date) _____
- ☐ Vaccination for Gardisil (Date) _____

Occupation: _____

9. REVIEW OF SYSTEMS

Constitutional

- ☐ Insomnia
- ☐ Unusual fatigue
- ☐ Weight gain
- ☐ Weight loss

Eyes

- ☐ Vision problems

HENT

- ☐ Lumps
- ☐ Neck stiffness

Breasts

- ☐ Pain
- ☐ Masses
- ☐ Discharge

Cardiovascular

- ☐ Chest pain
- ☐ Palpitations

Respiratory

- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Chronic cough

Gastrointestinal

- ☐ Nausea
- ☐ Abdominal pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Blood in stools
- ☐ Incontinence of gas
- ☐ Change in bowel habits
- ☐ Black tarry stools
- ☐ heartburn

Genitourinary

- ☐ Urgency
- ☐ Frequency
- ☐ Getting up at night
- ☐ (# of times _____)
- ☐ Incontinence (leaking of urine)
- ☐ Painful Urination

Integument (skin)

- ☐ Skin trouble

Neurologic

- ☐ Frequent headaches
- ☐ Fainting spells
- ☐ Dizzy spells

Musculoskeletal

- ☐ Joint pain
- ☐ Leg cramps
- ☐ Back pain
- ☐ Leg swelling

Endocrine

- ☐ Night sweats
- ☐ Hirsutism
- ☐ Hot flashes
- ☐ Loss of hair
- ☐

Psychiatric

- ☐ Anxiety
- ☐ Depression
- ☐ Excessive anger

Heme-Lymph

- ☐ Excessive bleeding
- ☐ Excessive bruising
- ☐ Swollen lymph nodes

Risk Assessment for Hereditary Cancer Syndrome

INSTRUCTIONS: **Please circle YES (Y)** to any statement below if it applies to **YOU or YOUR FAMILY MEMBERS.** Next to each statement, please list the **AGE** of the person when they were **DIAGNOSED** with cancer and your relation.

Consider the following family members on both your MOTHER and FATHER'S side:

You – Your Mother – Your Father – Your Brothers & Sisters – Your Children – Your 1st Cousins – Your Nieces & Nephews
Your Father's Brothers & Sisters and your Mother's Brothers & Sisters (Your Aunts and Uncles)
Your Father's Parents and your Mother's Parents (Your Grandmother & Grandfather) – Your Great Grandparents

Your Name:_____ **Date of Birth:**_____ **Your Doctor:**_____ **Date of Visit:**_____

	BREAST AND OVARIAN CANCER	You or Siblings	AGE	Mother's Side	AGE	Father's Side	AGE
Y / N	Have YOU had breast cancer at or before age 50			N/A	N/A	N/A	N/A
Y / N	Your MOTHER, SISTER, DAUGHTER, GRANDMOTHER, AUNT, or NIECE diagnosed with breast cancer at or before age 45						
Y / N	2 or more breast cancers on the same side of the family, 1 BEFORE age 50						
Y / N	3 or more breast cancers on the same side of the family, at ANY age						
Y / N	Ovarian Cancer in your family or YOU, at ANY age						
Y / N	Male Breast Cancer in your family, at ANY age						
Y / N	Triple Negative Breast Cancer in the family						
Y / N	3 or more of the following cancers on the same side of the family, at ANY age (breast, ovarian, prostate, or pancreatic)						
Y / N	Ashkenazi Jewish ancestry with ANY breast, ovarian or pancreatic cancer in the family						
Y / N	Is there a known BRCA Mutation in the family						
Y / N	Have you been tested for a BRCA mutation						
	COLON AND UTERINE CANCER	**You or Siblings**	**AGE**	**Mother's Side**	**AGE**	**Father's Side**	**AGE**
Y / N	Have YOU had COLORECTAL (Colon) before age 50, or UTERINE (Endometrial) cancer at ANY age			N/A	N/A	N/A	N/A
Y / N	2 or more COLORECTAL (Colon) CANCERS on the same side of the family, 1 BEFORE age 50						
Y / N	1 COLORECTAL CANCER AND 1 or more LYNCH SYNDROME CANCER (listed below) on the same side of the family, 1 BEFORE age 50						
Y / N	3 or more LYNCH SYNDROME CANCERS (listed below) on the same side of the family						

*Lynch Syndrome Cancers: Colorectal, Uterine/Endometrial, Ovarian, Gastric, Stomach, Pancreatic, Ureter, Bladder, & Brain

FOR OFFICE USE ONLY:

Did patient meet criteria for Genetic Testing? ☐ YES ☐ NO ☐ NO, but increased risk ☐ MORE INFORMATION NEEDED

If YES, Patient chose to: ☐ ACCEPT ☐ DECLINE

If MORE INFORMATION NEEDED, Follow-up appointment scheduled: Date:_____

PATIENT SIGNATURE for declined testing:_____ **Date:**_____

Provider's Signature:_____ **Date:**_____

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For your good health and well being, we as your health care providers encourage you to follow these preventative health care guidelines. If you have any questions or are in need of additional information, please ask!

PATIENT ANNUAL {Ages 13 - 18 years}

Pap smear - ACOG guidelines have changed to begin pap smears at age 21.
The HPV/Gardisil vaccine protects against cervical cancer and is recommended for all women under age 27.
Annual screen for Chlamydia by urine or pelvic exams recommended by all national organizations for all women under age 26. You may refuse this option.
Fasting lipid profile {cholesterol} every 5 years unless low risk.
Prevent unwanted / unintended pregnancy, postpone sexual involvement-discuss contraceptive options at your visit.
Prevent sexually transmitted diseases: abstain from sexual activity or use condoms every time.
Regular dental checkups: floss your teeth daily.
Exercise regularly: Cardiovascular exercise at least 60 minutes a day.
Wear sunscreen to prevent skin damage and skin cancer. May go without sunscreen for 30 minutes twice a week.
Prevent accidents: Wear your seat belt when driving. Wear a bike helmet when biking.
Adacel (Diptheria, Pertussis, Tetanus) vaccine once every 10 years. Let us know if you need this.
Hepatitis B vaccine, if you have not received it already.
Chicken Pox vaccine if you have not had chicken pox.
If you smoke, STOP! Please ask us for information to help you stop smoking!
Eat 3 servings of calcium a day {1000 mg}: milk, yogurt and calcium fortified orange juice are good sources. Bones grow until age 25.
Take a women's multivitamin every day for iron and folic acid supplementation.

PATIENT ANNUAL {Ages 19 - 39 years}

Pap smear - ACOG guidelines have changed to begin pap smears at age 21.
HPV testing with pap smear is available for women over 30. This allows for PAP testing every 5 years if HPV is negative. However, annual checkups with pelvic exams still are recommended.
Annual screen for Chlamydia by urine or pelvic exams recommended by all national organizations for all women under age 26. You may refuse this option.
Let your provider know if you prefer this option.
Fasting lipid profile {cholesterol} every 5 years unless low risk.
Prevent unwanted/unintended pregnancy, postpone sexual involvement-discuss contraceptive options at your visit.
Prevent sexually transmitted diseases - abstain from sexual activity or use condoms every time.
Regular dental checkups: floss your teeth daily.
Exercise regularly. Moderate level of exercise 150 minutes a week or vigorous level of exercise 75 minutes a week. There are increased benefits with longer duration and/or increased intensity exercise. If you need to lose weight, increase your exercise to 60 - 90 minutes a day most days of the week.
Wear sunscreen to prevent skin damage and skin cancer. May go without sunscreen for 30 minutes twice a week.
Prevent accidents: Wear your seat belt when driving. Wear a bike helmet when biking.
Adacel (Diptheria, Pertussis, Tetanus) vaccine once every 10 years.
Hepatitis B vaccine, if you have not received it already and are at risk (ask your provider).
Chicken Pox vaccine, if you have not had chicken pox.
Perform monthly breast self exams after your period.
If you smoke, STOP! Please ask us for information to help you stop smoking!
Eat 3 servings of calcium a day {100 mg}: milk, yogurt and calcium fortified orange juice are good sources.
Take a calcium supplement with Vitamin D if your diet is deficient.
Take a women's multivitamin every day for iron and folic acid supplementation.
Gardisil - The HPV vaccine that protects against cervical cancer is recommended for all women under age 27.

8/21/2014 update

_____
Patient Signature

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For your good health and well being, we as your health care providers encourage you to follow these preventative health care guidelines. If you have any questions or are in need of additional information, please ask!

PATIENT ANNUAL {Ages 40 - 64 years}

HPV testing with pap is recommended for women over 30. This allows for PAP testing every 5 years if HPV is negative. However, annual checkups with a pelvic exam are still recommended.
Fasting lipid profile {cholesterol} every 5 years.
Annual mammogram
TSH (thyroid) testing every 5 years starting at age 50.
Glucose testing every 3 years after age 45.
Colonoscopy at age 50 and every 10 years or as directed by your gastroenterologist.
Herpes zoster vaccine after age 60.
Regular dental checkups: floss your teeth daily.
Exercise regularly. Moderate level of exercise 150 minutes a week or vigorous level of exercise 75 minutes a week. There are increased benefits with longer duration and/or increased intensity exercise. If you need to lose weight, increase your exercise to 60 - 90 minutes a day most days of the week.
Wear sunscreen to prevent skin damage and skin cancer. May go without sunscreen for 30 minutes twice a week.
Prevent accidents: Wear your seat belt when driving. Wear a bike helmet when biking.
Prevent unwanted/unintended pregnancy, postpone sexual involvement-discuss contraceptive options at your visit.
Prevent sexually transmitted diseases: use condoms.
Tetanus - diptheria booster every 10 years. The Tetanus shot is recommended for all women ages 11-64. If your last shot was over 2 years ago, you should be revaccinated.
Discuss Hormone Replacement Therapy when you become menopausal.
Chicken Pox vaccine if you have not had chicken pox.
Perform monthly breast self exams after your period.
If you smoke, STOP! Please ask us for information to help you stop smoking!
Eat 4 servings of calcium a day {1200 mg}: milk, yogurt and calcium fortified orange juice are good sources.
Take a calcium supplement if your diet is deficient. If menopausal and not on hormone replacement therapy, take 5 servings a day {1500 mg} or a 1200 mg extended release tablet.
Take a women's multivitamin every day with folic acid and 1,000 IU Vitamin D.
Bone density at menopause.

PATIENT ANNUAL {Ages 65 years and older}

Monthly self breast exam.
Discontinue paps if appropriate after dicussion with your provider.
Yearly mammogram.
Regular cardiovascular exercise at least 3 times a week.
Exercise regularly. Moderate level of exercise 150 minutes a week or vigorous level of exercise 75 minutes a week. There are increased benefits with longer duration and/or increased intensity exercise. If you need to lose weight, increase your exercise to 60 - 90 minutes a day most days of the week.
Regular dental check ups.
Prevent motor vehicle injuries - wear seat belts and helmets.
Wear sunscreen to prevent skin damage from UV rays.
Cholesterol, high-density, lipoprotein every 3-5 years.
Glucose test every 3 years.
Prevent sexually transmitted diseases - use condoms.
Tetanus - diptheria booster every 10 years.
Hepatitis B vaccine, if at risk.
If you smoke, *STOP!* Please ask us for information to help you stop smoking!
Colonoscopy as directed by your Gastroenterologist.
Thyroid-stimulating hormone test every 3-5 years.
Discuss continuation of Hormone Replacement Therapy.
Influenza vaccine yearly.
Pneumococcal vaccine (once).
Herpes Zoster vaccine.

8/21/2014 update

_____
Patient Signature