ASHEVILLE WOMEN'S MEDICAL CENTER

YOUR CENTER OF EXCELLENCE FOR PERSONALIZED HEALTHCARE

We are delighted that you have chosen Asheville Women's Medical Center, P.A. as your health care provider. We appreciate the opportunity to serve you and are committed to your treatment and well-being. In an effort to reduce your wait time in the office, we have enclosed our patient information forms for you to complete and bring with you to the office on the day of your appointment. In addition to these information forms, please bring your current insurance card as well as a picture ID.

As a courtesy, we will file an insurance claim for you. However, you will be responsible for making your co-payment and/or deductible payment on the day of your appointment. Members of managed care plans need to obtain the appropriate authorization from their primary care physician if necessary. If you do not have insurance coverage, you are expected to pay for your visits at the time of each appointment. If you need to make financial arrangements prior to your appointment, please call our financial counselor at 258-9191 ext 314.

Please bring any pertinent medical records from other physicians with you to your visit, along with a complete list of all current medications. Patients having a mammogram will need to have any previous films sent to us.

Please notify us at least 24 hours in advance if you cannot keep your scheduled appointment. Our office will call to confirm your ability to keep your scheduled appointment one week prior. If you fail to confirm through the automated system or to call at least 24 hours prior to that appointment, you will be charged a $25 fee. Please be aware that if you fail to come in for your appointment, or do not give at least 24 hours of cancellation, we may not be able to reschedule your appointment for a future date.

We look forward to seeing you soon. In the mean time, do not hesitate to call me directly if you have any questions. You can feel confident that the doctors and staff of Asheville Women's Medical Center will provide the care you need and deserve.

143 Asheland Avenue
Asheville, NC 28801
(828) 258-9191

310 Long Shoals Road, Suite 202
Arden, NC 28704
(828) 687-2955

ASHEVILLE WOMEN'S MEDICAL CENTER

YOUR CENTER OF EXCELLENCE FOR PERSONALIZED HEALTHCARE

REGISTRATION FORM

Today's date	Chart #	Social Security #

PATIENT INFORMATION

Patient's Last Name	First	Middle Initial	Address

City:	State	Zip Code	Home #	Work #	Cell #

Date of Birth / /	Employer/School	Employer Address	Employed/Student ❑ FT ❑ PT ❑ Self ❑ Military

Email Address (if applicable)	Referred to AWMC by Dr.

Primary Care Physician	**Primary Care Phone #**	Marital Status ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widow

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

We must have this information in order to file your insurance

Primary Insurance Company Name:

Subscriber's Name	Subscriber's S.S. #	Subscriber's Birth date / /	Group #/ ID #	Policy #	Co-payment $

Patient's relationship to subscriber	❑ Self	❑ Spouse	❑ Child	❑ Other

Subscriber's Employer	Employer Address	Employer Phone #

Secondary Insurance Company Name: (if applicable)

Subscriber's Name	Subscriber's S.S. #	Subscriber's Birth date / /	Group #/ ID #	Policy #	Co-payment $

Patient's relationship to subscriber	❑ Self	❑ Spouse	❑ Child	❑ Other

Subscriber's Employer	Employer Address	Employer Phone #

IN CASE OF EMERGENCY

Name of local friend or relative	Relationship to patient	Home phone #	Work phone #

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize Asheville Women's Medical Center to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by my insurance. **As the responsible party, I agree that all charges not directly paid by my insurance company will be my responsibility.**

_____ _____

Patient/Guardian signature *Date*

ASHEVILLE WOMEN'S MEDICAL CENTER

A Comprehensive Health Care Questionnaire

Chart#_____ Date_____

Name_____ Date of Birth_____Age_____
First Last Middle

Address_____
Street City State Zip

Occupation_____Place of Employment_____Marital Status S M W D

Your Phone Numbers (H) _____(W) _____Spouse or Support Person_____Phone_____

Where were you born? _____Education_____

Family Physician_____ Who were you referred by? _____

****

Medications and Dose

(Include over-the-counter, prescription dugs, and herbal remedies

_____
_____
_____
_____

Menstrual History

Age of onset_____
Frequency_____
Duration of flow in days_____
Pain with menstrual flow(0 1 2 3 4 5)
Do you lose work due to menses? Y/N
Do you take medication for menses? Y/N

Birth Control

(circle type used)

Birth control pills/patch/ring/depo provera
Barrier: condom/ foam gel / diaphragm
tubal / male vasectomy / IUD

Allergies to Medication:

_____
_____

Surgeries and/or Biospies (Including date, type, hospital and surgeon)

_____
_____
_____
_____
_____
_____
_____
_____
_____

Pregnancy History

How many times pregnant? _____
How many children? _____
Miscarriages ? Y / N
Abortions? Y / N
Ectopics? Y / N
C-Section? Y/ N
Complications of pregnancy? Y / N
If yes, please describe:_____
_____
_____
_____
_____

Family and Social History

Living situation_____
Children names and date of birth:
_____
_____
_____
Sexually active Y / N
Have you / Do you smoke? Y / N
Packs per day_____
Do you use tobacco in other forms? Y / N
Describe_____
How much alcohol do you use? units/day ____
Do you drink caffeinated drinks? units/day____
Do you exercise regularly? Y / N

****

Do you now have or did you ever have:

Abnormal Pap Test	Yes	No	Asthma	Yes	No	Bladder infection	Yes	No
Bleeding disorder	Yes	No	Bloody or tarry stools	Yes	No	Bone or joint problems	Yes	No
Breathing problems	Yes	No	Bloody urine	Yes	No	Blood transfusion	Yes	No
Change in bowel habits	Yes	No	Chest pain/heart trouble	Yes	No	Cancer any site	Yes	No
Colitis	Yes	No	Depression/related illness	Yes	No	Diabetes	Yes	No
DES exposure	Yes	No	Elevated cholesterol	Yes	No	Excessive loss of urine	Yes	No
"Female" cancer	Yes	No	Hepatitis/Jaundice	Yes	No	High blood pressure	Yes	No
Infertility	Yes	No	Kidney disorder	Yes	No	Migraine headaches	Yes	No
Miscarriage/abortion	Yes	No	Mental illness	Yes	No	Pelvic Infection(nonvaginal)	Yes	No
Sexual assault/familyviolence	Yes	No	Shortness of breath	Yes	No	Thyroid problems	Yes	No
Weight control problems	Yes	No	Water retention/edema	Yes	No			

Family History: parents/grandparents/siblings

Birth defects	Yes	No	Breast cancer	Yes	No	Colon Cancer	Yes	No
Diabetes	Yes	No	Heart attack	Yes	No	Heart disease	Yes	No
High blood pressure	Yes	No	Osteoporosis	Yes	No	Ovarian cancer	Yes	No
Stroke	Yes	No						

Health Screening History

Last colonoscopy/sigmoidoscopy normal?	Yes	No	Date_____	Last bone density normal?	Yes	No	Date_____	
Last breast ultrasound normal?	Yes	No	Date_____	Last blood work normal?	Yes	No	Date_____	
Last pap test normal?	Yes	No	Date_____	Last mammogram normal?	Yes	No	Date_____	

Please describe your main problem:_____

_____

Cancellation and Missed Appointment Policy

Our goal is to provide quality individualized medical care in a timely manner. "No-shows" and late cancellations inconvenience those individuals who need access to medical care in a timely manner. We would like to remind you of our office policy regarding missed appointments. This policy enables us to better utilize available appointments for our patients in need of medical care.

Cancellation of an Appointment:

In order to be respectful of the medical needs of other patients, please be courteous and call the Asheville Women's Medical Center promptly if you are unable to keep an appointment. This time will be reallocated to someone who is in need of treatment. If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely medical care.

How to Cancel Your Appointment:

To cancel appointments, please call 828-258-9191. If you do not reach the receptionist, you may leave a detailed message on our voicemail. If you would like to reschedule your appointment, please leave your phone number. We will return your call and give you the next available appointment time.

Late Cancellations:

A late cancellation is considered when a patient fails to cancel their scheduled appointment with a 24-hour advance notice.

No Show Policy:

A "no-show" is someone who misses an appointment without cancelling it in an adequate time frame and manner. A failure to be present at the time of a scheduled appointment will be recorded in your medical record as a "no-show."

- First missed appointment: $25 fee will be billed to your account
- Second missed appointment: $50 fee will be billed to your account
- Third missed appointment: $50 fee will be billed to your account and you may be discharged from our practice

Please sign and date below indicating that you have read and agree to this policy.

Name_____ Date_____

ASHEVILLE WOMEN'S MEDICAL CENTER
143 ASHELAND AVENUE
ASHEVILLE, NC 28801
PHONE: (828) 258-9191 FAX: (828) 253-7382

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize _____ to use and/or disclose certain protected health information (PHI) about me to _____

_____.

This authorization permits the disclosure of the following individually identifiable health information about me:

_____ All Records _____ Records from (specify date) _____

_____ Specific Information _____

_____ Specific Information to be excluded _____

_____ I do _____ I do not authorize release of information related to AIDS or HIV Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

The information will be used or disclosed for the following purpose:

_____ Changing Physicians _____ Additional Physicians

_____ Insurance Claim _____ At my request

_____ Other (Specify) _____

THIS AUTHORIZATION WILL AUTOMATICALLY EXPIRE ONE YEAR FROM THE DATE SIGNED.

I do not have to sign this authorization in order to receive treatment from Asheville Women's Medical Center. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at: 143 Asheland Avenue, Asheville, NC 28801.

Signed by: _____ _____
Signature of Patient or Legal Guardian | Relationship to Patient

_____ _____
Mailing Address | City State Zip Code

_____ _____
Print Name of Patient or Legal Guardian | Social Security Number

_____ _____
Date of Birth | Date Telephone Number

_____ _____
Witness | Medical Record Number/ Provider

NOTE: Federal and State laws permit a fee to be charged for the copying of patient records. HealthPort has been contracted to provide the service of medical records request. Currently, the charge is $0.75 (1-25 pgs) $0.50 (26-100) $0.25 (101+) plus actual postage for the Patient Personal Requests. Prices are subject to change without notice. HealthPort can be reached at 1-800-367-1500.

Asheville Women's Medical Center, P.A.

NOTICE OF PRIVACY PRACTICES

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your IIHI
- Your privacy rights in your IIHI
- Our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Privacy Officer @ AWMC, 143 Asheland Ave, Asheville, N.C., 28801

C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your IIHI.

1. Treatment. Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your IIHI in order to write a prescription for you, or we might disclose your IIHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice – including, but not limited to, our doctors and nurses – may use or disclose your IIHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your IIHI to others who may assist in your care, such as your spouse, children or parents.

2. Payment. Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your IIHI to bill you directly for services and items.

3. Health Care Operations. Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice

4. Appointment Reminders. Our practice may use and disclose your IIHI to contact you and remind you of an appointment

5. Treatment Options. Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.

6. Health-Related Benefits and Services. Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you

7. Release of Information to Family/Friends. Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to the pediatrician's office for treatment of a cold. In this example, the babysitter may have access to this child's medical information.

8. Disclosures Required By Law. Our practice will use and disclose your IIHI when we are required to do so by federal, state or local law.

D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public Health Risks. Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:

- maintaining vital records, such as births and deaths
- reporting child abuse or neglect
- preventing or controlling disease, injury or disability
- notifying a person regarding potential exposure to a communicable disease
- notifying a person regarding a potential risk for spreading or contracting a disease or condition
- reporting reactions to drugs or problems with products or devices
- notifying individuals if a product or device they may be using has been recalled
- notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic
- notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. Health Oversight Activities. Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and Similar Proceedings. Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. Law Enforcement. We may release IIHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
- Concerning a death we believe has resulted from criminal conduct
- Regarding criminal conduct at our offices
- In response to a warrant, summons, court order, subpoena or similar legal process
- To identify/locate a suspect, material witness, fugitive or missing person
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description,

identity or location of the perpetrator.)

5. Deceased Patients. Our practice may

coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

6. Organ and Tissue Donation. Our practice may release your IIHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

7. Research. Our practice may use and disclose your IIHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your IIHI for research purposes except when: (a) our use or disclosure was approved by an Institutional Review Board or a Privacy Board; (b) we obtain the oral or written agreement of a researcher that (i) the information being sought is necessary for the research study; (ii) the use or disclosure of your IIHI is being used only for the research and (iii) the researcher will not remove any of your IIHI from our practice; or (c) the IIHI sought by the researcher only relates to decedents and the researcher agrees either orally or in writing that the use or disclosure is necessary for the research and, if we request it, to provide us with proof of death prior to access to the IIHI of the decedents.

8. Serious Threats to Health or Safety. Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

9. Military. Our practice may disclose your IIHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

10. National Security. Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

11. Inmates. Our practice may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individual

12. Workers' Compensation. Our practice may release your IIHI for workers' compensation and similar programs.

E. YOUR RIGHTS REGARDING YOUR IIHI

You have the following rights regarding the IIHI that we maintain about you:

1. Confidential Communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to: **Privacy Officer @ AWMC, 143 Asheland Avenue, Asheville, N.C., 28801** specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate **reasonable** requests. You do not need to give a reason for your request.

2. Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your IIHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request**; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your IIHI, you must make your request in writing to: **Privacy Officer @ AWMC, 143 Asheland Ave., Asheville, N.C., 28801.** Your request must describe in a clear and concise fashion:

(a) the information you wish restricted;

(b) whether you are requesting to limit our practice's use, disclosure or both; and

(c) to whom you want the limits to apply.

3. Inspection and Copies. You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to: **Privacy Officer @ AWMC, 143 Asheland Avenue, Asheville, N.C., 28801** in order to inspect and/or obtain a copy of your IIHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to: **Privacy Officer @ AWMC, 143 Asheland Avenue, Asheville, N.C., 28801.** You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the IIHI kept by or for the practice; (c) not part of the IIHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of Disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your IIHI for non-treatment or operations purposes. Use of your IIHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request **AWMC, 143 Asheland Avenue, Asheville, N.C., 28801.** All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact **Privacy Officer @ AWMC, 143 Asheland Avenue, Asheville, N.C., 28801.**

7. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact: **Privacy Officer @ AWMC, 143 Asheland Avenue, Asheville, N.C., 28801.** All complaints must be submitted in writing. **You will not be penalized for filing a complaint**.

8. Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your IIHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your IIHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact: **Privacy Officer @ AWMC, 143 Asheland Ave., Asheville,N.C., 28801.**

Effective Date of this Notice: April 14, 2003