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 billing department at 253-9632.

Please have any pertinent medical records from other physicians faxed to our office prior to your visit. This will allow your visit to be much more productive and help facilitate the care you need. We have included a medical records release for your convenience. 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 $75 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 meantime, 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
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 **Asheville Women's Medical Center**

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

__X__ **ALL NEW PATIENTS:** Last three pap smear/co-testing results. And, if applicable, last breast imaging reports, last bone density report, last colonoscopy report

_____ All OB/GYN Relevant Records

_____ Specific Information _____

_____ Specific Information to be excluded _____

****All types of information found in the records selected above will be provided (if applicable), including information that may be viewed as sensitive; such as alcohol, drug abuse, genetic information, psychiatric, STD testing and/or results, HIV testing, HIV results or AIDS information. Specify any information above you would like to have excluded.**

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	Last 4 digit SSN
_____	_____
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. 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.

ASHEVILLE WOMEN'S MEDICAL CENTER **Chart # _____**

A Comprehensive Health Care Questionnaire Date _____

Name_____ Date of Birth _____ Age_____
First Last Middle

Address_____
Street City State Zip

Phone Numbers (H) _____ (W) _____ Spouse or Support Person _____ Phone_____

****

Pharmacy _____ Primary Care Physician _____

Height _____ Weight _____

Allergies: _____

Medications and Dose: (include over-the-counter and prescription drugs) _____

_____ _____

_____ _____

_____ _____

Supplements and Dose: _____

Vaccines: FLU ☐ YES ☐ NO If yes, date of last: _____

COVID ☐ YES ☐ NO If yes, dates: _____

GARDASIL / HPV ☐ YES ☐ NO If yes, dates: _____

****

GYN HISTORY LMP date: _____ Sexually active ☐ YES ☐ NO Age of first menses _____

Current birth control_____ Age at menopause _____

DATE OF LAST: MAMMOGRAM _____ RESULT _____

COLONOSCOPY _____ RESULT _____

BONE DENSITY _____ RESULT _____

PAP SMEAR _____ RESULT _____

HIGH RISK HPV TEST _____ RESULT _____

History of abnormal pap smear ☐ YES ☐ NO; if yes please explain_____

DES Exposure ☐ YES ☐ NO

****

OBSTETRIC HISTORY Number of pregnancies _____ Number of children _____

Past pregnancies (dates of delivery)_____

History of Miscarriages or Abortion ☐ YES ☐ NO

FAMILY HISTORY: parents / grandparents / siblings

Breast Cancer ☐ YES ☐ NO relation: _____ Ovarian Cancer ☐ YES ☐ NO relation: _____

Colon Cancer ☐ YES ☐ NO relation: _____ Birth defects ☐ YES ☐ NO relation: _____

Diabetes ☐ YES ☐ NO relation: _____ High blood pressure ☐ YES ☐ NO relation: _____

Stroke ☐ YES ☐ NO relation: _____ Heart attack ☐ YES ☐ NO relation: _____

Other _____

****

SOCIAL HISTORY Gender at birth: FEMALE / MALE Identify as: FEMALE / MALE / OTHER:_____

Relationship status: Married / Single / Divorced / Separated / Widowed / Domestic Partner / Other

Spouse / Partner's Name: _____

Your Occupation: _____ Place of Employment: _____

Type of diet: Regular / Vegetarian / Vegan / Gluten Free / Other: _____

Exercise level: None / Occasional / Moderate / Heavy

Smoking Status: Never / Former / Current Smoker Do you use other forms of tobacco or nicotine? ☐ YES ☐ NO

Alcohol consumption: None / Occasional / Moderate / Heavy **Caffeine consumption**: None / Occasional / Moderate / Heavy

****

SURGICAL HISTORY

List surgeries and/or biopsies (Including date, type, hospital, and surgeon)

_____ _____
_____ _____
_____ _____
_____ _____

PAST MEDICAL HISTORY

Attention Deficit Disorder (ADD / ADHD) □ YES □ NO

Cancer – Breast □ YES □ NO
Cancer – Cervical □ YES □ NO

Cancer – Colon □ YES □ NO
Cancer – Endometrial / Uterine □ YES □ NO

Cancer – Lung □ YES □ NO

Cancer – Skin □ YES □ NO

Cancer – Vaginal □ YES □ NO
Cancer – Vulvar □ YES □ NO

Cardiology – Heart Arrhythmia □ YES □ NO

Cardiology – Heart Disease □ YES □ NO
Cardiology – High Blood Pressure □ YES □ NO

Cardiology – High Cholesterol □ YES □ NO
Dermatology – Acne □ YES □ NO
Dermatology – Eczema / Psoriasis □ YES □ NO

ENT – Hearing Loss □ YES □ NO

ENT – Seasonal Allergies / Allergic Rhinitis □ YES □ NO
Endocrinology – Diabetes □ YES □ NO
Endocrinology – Glucose Intolerance / Insulin Resistance □ YES □ NO
Endocrinology – History of Gestational Diabetes □ YES □ NO
Endocrinology – Hyperthyroidism □ YES □ NO
Endocrinology – Hypothyroidism □ YES □ NO
Endocrinology – Osteopenia □ YES □ NO
Endocrinology – Prolactinoma □ YES □ NO
Endocrinology – Thyroid Problems □ YES □ NO
Endocrinology – Vitamin Deficiency □ YES □ NO
Eyes – Glaucoma □ YES □ NO
Eyes – Vision Loss / Macular Degeneration □ YES □ NO
GI – Colon Polyps □ YES □ NO
GI – Crohn's / Ulcerative Colitis □ YES □ NO
GI – Gallbladder Disease □ YES □ NO
GI – Hemorrhoids □ YES □ NO
GI – Irritable Bowel Syndrome □ YES □ NO
GI – Liver Disease / Hepatitis □ YES □ NO
GI – Reflux / Ulcers □ YES □ NO

GYN – Dysplasia □ YES □ NO
GYN – Endometriosis □ YES □ NO
GYN – Fibroids □ YES □ NO
GYN – Infertility □ YES □ NO
GYN – PCOS □ YES □ NO
Hematology – Anemia □ YES □ NO
Hematology – Bleeding Disorder □ YES □ NO
Hematology – Blood Clotting Disorder / Factor V Leiden □ YES □ NO
Hematology – Blood Transfusion □ YES □ NO
Hematology – DVT / Pulmonary Embolism □ YES □ NO
Hematology – Other □ YES □ NO
ID – Tuberculosis / Positive PPD □ YES □ NO
ID – Chicken Pox / Shingles □ YES □ NO
ID – HIV □ YES □ NO
ID – Herpes □ YES □ NO
ID – MRSA □ YES □ NO
Nephrology – Renal Disease □ YES □ NO
Neurology – Dementia □ YES □ NO
Neurology – Headaches / Migraines □ YES □ NO
Neurology – Multiple Sclerosis □ YES □ NO
Neurology – Seizures / Epilepsy □ YES □ NO
Neurology – Stroke / TIA □ YES □ NO
Ortho – Arthritis □ YES □ NO
Ortho – Chronic Back Pain □ YES □ NO
Ortho – Fractures □ YES □ NO
Psych – ADD □ YES □ NO
Psych – Anxiety Disorder □ YES □ NO
Psych – Bipolar Disease □ YES □ NO
Psych – Depression □ YES □ NO
Psych – Eating Disorder □ YES □ NO
Psych – PMS / PMDD □ YES □ NO
Pulmonary – Asthma □ YES □ NO
Pulmonary – COPD / Emphysema □ YES □ NO
Pulmonary – Seasonal Allergies □ YES □ NO
Pulmonary – Sleep Apnea □ YES □ NO
Rheumatology – Arthritis □ YES □ NO
Rheumatology – Autoimmune Disease □ YES □ NO
Rheumatology – Fibromyalgia / Chronic Pain □ YES □ NO
Rheumatology – Restless Leg Syndrome □ YES □ NO
Urology – Hematuria (Blood in urine) □ YES □ NO
Urology –Interstitial Cystitis □ YES □ NO
Urology –Recurrent Urinary Tract Infections □ YES □ NO
Urology –Stones □ YES □ NO
Urology – Urinary Incontinence □ YES □ NO
Vascular – Aneurysm □ YES □ NO
Weight Management / Obesity □ YES □ NO

OTHER: _____ _____
_____ _____
_____ _____
_____ _____

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 and last minute cancellations. This policy enables us to better utilize available appointments for other patients in need of timely medical care.

Cancellation of an Appointment:

In order to be respectful of the medical needs of other patients, please be courteous and call 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 828-258-9191 at least 24 hours in advance. Appointments are in high demand, and your early cancellation will give another person the opportunity to access timely, high quality medical care.

How to Cancel Your Appointment:

To cancel appointments, please call 828-258-9191.

Last Minute Cancellations:

A late cancellation is considered when a patient fails to cancel their scheduled appointment with 24-hour advance notice. A failure to cancel a scheduled appointment more than 24 hours prior will be recorded in your medical record as a "late cancellation".

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."

Fees for Late Cancellations or No Shows for Established Patients:

- First late cancellation or no show for established patients: $50 fee will be billed to your account and will need to be paid prior to your rescheduled appointment
- Second late cancellation or no show for established patients: $75 fee will be billed to your account and your care team will decide if the appointment can be rescheduled
- Third late cancellation or no show for established patients: You will be discharged from our practice.

Fees for Late Cancellations or No Shows for New Patients:

- First late cancellation or no show for new patients: $75 fee will be billed to your account and will need to be paid prior to your rescheduled appointment
- Second late cancellation or no show for new patients: $100 fee will be billed to your account and you will be discharged from our practice.

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

Name_____ Date_____

REGISTRATION FORM

(Please Print)

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	**Employed** ☐ FT ☐ PT ☐ Self ☐ Military	**Student** ☐ FT ☐ PT	**Preferred Language** ☐ English ☐ Spanish ☐ Russian ☐ Other ☐ Sign Language ☐ Decline

Email Address (if applicable)	**Race** ☐ American Indian or Alaska Native ☐ Asian ☐ Other ☐ Black or African American ☐ Native Hawaiian ☐ White ☐ Pacific Islander ☐ More than One Race ☐ Decline

Primary Care Physician	**Primary Care Phone #**	**Ethnicity** ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline	**Marital Status** ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

IN CASE OF EMERGENCY

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

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-Paymer $

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-Paymer $

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

Subscriber's Employer	Employer Address	Employer 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 responsib 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 _____