Contemporary Women's Care

Patient Registration/Demographics

PLEASE PRINT & FILL OUT COMPLETELY!

PERSONAL INFORMATION:

NAME: _____ EMAIL: _____

DATE OF BIRTH: _____ SS #: _____ MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

RESPONSIBLE PARTY INFORMATION:

NAME: _____ DATE OF BIRTH: _____ SS# _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

RELATION TO PATIENT: _____

INSURANCE INFORMATION:

PRIMARY INSURANCE

INSURED NAME: _____ RELATION TO PATIENT: _____

INSURANCE CO: _____ POLICY #: _____ GROUP #: _____

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

SECONDARY INSURANCE

INSURED NAME: _____ RELATION TO PATIENT: _____

INSURANCE CO: _____ POLICY #: _____ GROUP #: _____

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

REFERRAL INFORMATION :

NAME: _____ RELATION TO PATIENT: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

PHONE: _____ FAX: _____

PHARMACY INFORMATION :

NAME OF PHARMACY: _____ PHONE: _____ FAX: _____

CROSS STREETS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

EMERGENCY CONTACT :

NAME: _____ RELATION TO PATIENT: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

Signature: _____ Date: _____

Contemporary Women's Care

Dr. Ali Baradaran

2899 N 87th St. Suite 110

Scottsdale, AZ 85257

P (480)491-5886 F (480)491-3388

Financial Agreement

We are committed to providing you with the best and most caring service possible. If you have medical insurance, we want to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our payment policies.

A payment for services NOT COVERED by your insurance plan is due at the time of service. Payment for services DENIED by your insurance plan is due immediately upon receipt of a statement from our office. We accept cash, checks, debit cards, Visa cards and Mastercards as forms of payment. We will be happy to file your claims with your insurance plan if we are listed as a "Participating Provider". You must realize, however, that:

- Your insurance contract is between you, the insurance company, and (possibly) your employer. We are not a party to the contract and are not responsible for knowing specific benefits for your plan.
- We will file your claims with plans we participate with only if we have a current copy of your insurance card and all pertinent information required for filing claims (social security number, date of birth, etc.)
- If we are unable to verify benefits for a same day procedure, you will be asked to pay self-pay or reschedule. If you choose self-pay, we will file for the procedure and upon receipt of the insurance explanation of benefits a refund would be made to you if a credit balance exists.
- Not all services are a covered benefit under your insurance contract. Some insurance companies arbitrarily select certain services they will not cover or they may set maximum limitations. Any services identified as such are the patient's responsibility and will be due at time of service.
- If your plan requires a referral from a PCP before seeing a specialist, it is the patient's responsibility to obtain that authorization prior to being seen in our office.

We must emphasize that the filing of claims is a courtesy that we extend to our patients. All charges are the patient's responsibility from the date the service is rendered. It is understood the temporary financial problems may affect timely payment on patient's accounts. If such problems arise, please contact us immediately for assistance in the management of your account. If you have questions regarding this at any point in your care, do not hesitate to ask.

I hereby authorize Contemporary Women's Care to furnish my insurance company, its representatives or any other insurance company or attorney, the customary medical information requested about me. I understand that Contemporary Women's Care will file my insurance on my behalf and that I will be responsible for following up with my insurance company for timely payment of services rendered. I agree to pay all balances due that are not paid for by my insurance company.

Patient Signature: _____ Date: _____

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HIPAA NOTICE OF PRIVACY RIGHTS

This notice describes how medical information about you may be used and disclosed and how you can gain access to this information. Please review it carefully. This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or healthcare operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operations of the physicians practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physicians practices. These activities include, but are not limited to, quality assessment, employee review, training of medical students, outsourcing to a foreign country, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our clinic. In addition, we may use a sign in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health related benefits and services that may be of interest to you.

We may use and disclose your protected health information in the following situations without your authorization.

These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon request.

Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child or elder abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been the victim of abuse, neglect, or domestic violence to the government entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceedings, in response to an order of the court or administrative tribunal (to extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful legal process.

Workers Compensation: We may disclose your protected health information as authorized to comply with the workers compensation laws and other similar legally established programs.

Other Permitted and Required Uses & Disclosures: Will be made only with your consent, authorization or opportunity to object unless required by law. You may revoke the authorization, at any time, in writing, except to the extent that your physician or physician's practice has taken an action in reliance on the uses or disclosure indicated in the authorization.

YOUR RIGHTS

The following statements of you rights with respect to your protected health information

You have the right to inspect and copy your protected health information (fees may apply)-Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request restriction of your protected health information-This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members of friends who may be involved in your care or for notification purposed described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to your requested restriction.

You have the right to request to receive confidential communications-You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively (i.e. electronically).

You have the right to request an amendment to your protected health information-If we deny you request for an amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures-You have the right to receive an accounting of all disclosures except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of this request.

You have the right to obtain a paper copy of this notice even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and will notify you of such changes at the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS

You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. We will not retaliate against you for making a complaint.

We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of this notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone.

Please note that by signing this document you are only acknowledging that you have received or been given an opportunity to receive a copy of our three page Notice of Privacy Practices.

PROTECTED HEALTH INFORMATION AUTHORIZATION

Please allow access of my Protected Health Information (PHI) to:

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Registrations pertaining to medical assignment of benefits apply. If not signed by patient, please indicate relationship (e.g. spouse).

Print Name: _____ Relationship: _____

Signature: _____ Date: _____

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HIV Consent

Information on HIV: The Human Immunodeficiency Virus (HIV) is the virus that causes Acquired Immune Deficiency Syndrome (AIDS). HIV is contracted and/or spread through the exchange of blood, sexual fluids, and sometimes through breast milk. HIV can be transmitted from the mother to the baby during pregnancy or childbirth.

HIV Testing: There are several HIV-related lab tests. The most common is the antibody test, which is a blood test that detects the antibodies produced in the body in response to infection with HIV. A negative antibody test indicates that no detectable antibodies are present in the blood. The absence of antibodies may be because an individual isn't infected with HIV OR because detectable antibodies have not been made yet in response to infection. The production of these antibodies could take three months or longer. Therefore, in certain cases, an individual may be infected with HIV and still test negative. Persons with a history of HIV risk behaviors within the past three months should consider retesting. A positive antibody test generally consists of a repeatedly reactive (the same specimen testing positive twice), enzyme immunoassay (EIA) and a reactive Western blot (confirmatory test). A positive test means that an individual is infected with HIV. However, it doesn't necessarily mean that the individual has AIDS or will develop AIDS. Research indicates that early and regular medical supervision are important to determine immune status and to provide guidance that can lengthen life expectancy. Certain medications are now available to delay HIV-associated illness.

Means to reduce risk for contracting/spreading HIV: Risk of contracting or spreading HIV can be reduced by avoiding or decreasing contact with blood and sexual fluids. Some methods of decreasing contact include: abstaining from sexual intercourse, limiting the number of sexual partners, the proper use of condoms, not engaging in intravenous drug use, and using "universal precautions" when possible contact with blood and other bodily fluids is unavoidable.

Disclosure of test results: Positive HIV test results will be reported to local and state health departments. This information is protected by law and may be released only upon the tested individual's written authorization or for statistical purposes without individual identifying information.

Additional Sources of Information on HIV: Additional information regarding HIV testing is available through your county health department and in the Phoenix metropolitan area (602)234-2752, in the Tucson area (520)326-8437, or toll free (800)334-1540.

- ☐ I GIVE MY CONSENT AND REQUEST TO HAVE HIV TESTING
- ☐ I HAVE READ THE ABOVE INFORMATION AND DECLINE TO HAVE HIV TESTING

Print Name: _____ Signature: _____ Date: _____

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New Patient Medical History Questionnaire

Patient Name: _____ DOB: _____ Date: _____

Please briefly explain the reason for your visit:

_____

_____

_____

_____

Gynecological History

First day of last menstrual period: _____

Do you have a normal menstrual cycle? Y N Do you experience emotional changes? Y N

My menstrual cycle occurs every _____ days and usually lasts _____ days.

I use _____ pads/tampons per day when menstruating. Age menstrual cycle began: _____

During my cycle I experience: ____ Cramps ____ Diarrhea ____ Swelling

Bleeding between periods: None Light Moderate Heavy Heavy w/Clots

Substance Use History

Do you smoke? Y N Do you drink? Y N

Do you use recreational drugs? Y N If yes, what kind/how often? _____

Sexual History

Are you sexually active? Y N More than 1 partner? Y N

Do you have sex with: Men Women Both

Do you experience pain with intercourse? Y N How long with current partner? _____

Do you practice: Vaginal Sex Oral Sex Anal Sex

Have you been exposed to: Multiple Partners IV Drug Users Gay or Bisexual Partners

Do you have any reason to believe that you have been exposed to AIDS or an HIV positive partner? Y N

Have you been treated for: Chlamydia Herpes Genital Warts Trichomisis Hep B

Syphillis Gonorrhea Other: _____

Have you ever had an infection of the uterus, tubes or ovaries: Y N If yes, which one? _____

When? _____ Were you hospitalized? Y N Hospital: _____

Periodic Physical History

Date of last Pap Smear: _____ Ever had an abnormal Pap Smear? Y N If yes, when? _____

Was there treatment of follow up? Y N If yes, what type? _____

Do you perform monthly breast exams? Y N Are you currently breastfeeding? Y N

Do you have nipple discharge or leaking? Y N Do you hace breast problems? Y N

If yes, please explain:

_____

_____

Have you ever had a mammogram? Y N If yes, when? _____

Does anyone on your mother's side of the family have/had breast cancer? Y N

Personal Medical History

Have you ever been treated for:

Bowel Issues Lung Problems Cardiac Problems Stomach Problems

Liver Problems If yes, please explain: _____

Have you ever had:

Stroke Bladder Infection Kidney Infection Psychiatric Care

High Blood Pressure Blood Clots Elevated Cholesterol Blood Transfusion

Anemia Varicose Veins Bleeding Disorders Chest Pains Migraines Fainting Spells

Concussion Seizures Thyroid Issues Diabetes Cancer Depression

Recent Weight Change Bone Problems Muscle Problems

Have you ever taken hormones? Y N If yes, have you taken: Estrogen Estrogen/Progesterone

Are there any other medical problems, not mentioned, that we should know about?

_____

_____

_____

Do you have any allergies to medication or food? Y N If yes, explain: _____

Are you currently taking any medications? Y N If yes, please list: _____

_____

Pregnancy History

Have you ever been pregnant? Y N

DELIVERY DATE	DELIVERY TYPE	COMPLICATIONS
1.		
2.		
3.		
4.		
5.		

Family Planning

Oral Contraceptive: Past / Present / Never

Depo Provera: Past / Present / Never

IUD (Merina or Paragaurd): Past / Present / Never

Diaghragm: Past / Present / Never

Condoms: Past / Present / Never

Tubal Ligation: Past / Present / Never

Vasectomy: Past / Present / Never

Foam/Vaginal Insert: Past / Present / Never

Desired birth control method? _____

What are your future pregnancy plans? _____

Family History

High Blood Pressure:	Y	N	Who? _____
High Cholesterol:	Y	N	Who? _____
Heart Disease:	Y	N	Who? _____
Breast Cancer:	Y	N	Who? _____
Uterine Cancer:	Y	N	Who? _____
Ovarian Cancer:	Y	N	Who? _____
Any other form of Cancer:	Y	N	Who? _____
Diabetes:	Y	N	Who? _____
Genetic Disorders:	Y	N	Who? _____

Past Surgeries or Hospitalizations

MONTH/YEAR	ILLNESS/OPERATION	COMPLICATIONS

I have read and completed the New Patient Medical History Form to the best of my knowledge. I have neither left out nor falsified any of the information.

Patient Signature: _____ Date: _____

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MEDICAL RECORDS RELEASE

NAME: _____ DATE OF BIRTH: _____

____ I hereby authorize Contemporary Women's Care to **RECEIVE** my medical records from the provider listed below.

____ I hereby authorize Contemporary Women's Care to **SEND** my medical records to the provider listed below.

Please send:

- ☐ ALL Records
- ☐ Specific Items:

_____

_____

_____

Provider/Facility Name: _____

Address: _____

City/State/Zip: _____ Phone: _____ Fax: _____

Signature: _____ Date: _____

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Missed Appointment Policy

As of May 1, 2014 there has been a change to our scheduled appointment policy with all patients. Due to many no-show and late reschedules, we are being forced to begin charging patients that do not give at least 24 hour notice prior to cancelling or rescheduling an appointment with Dr. Baradaran or our Ultrasound Technician Amy Hickey. There will be a charge of $25.00 for patients that do not cancel or reschedule their appointments within that 24 hour window. We work hard to assist all our patient's needs, and appreciate you respecting our time by being on time to scheduled appointments.

Changes to Insurance & Demographics

Patients are responsible for notifying the office immediately if there are any changes to: insurance coverage information, address or phone number. It is our goal to minimize the amount of inconveniences to our patient, and keeping your information current with our office is an important factor in making sure you're given the best treatment possible.

By signing this form you are acknowledging that you have read and understood the policies regarding missed appointments, changes to insurance coverage, and changes to address and phone number, and you are willing to cooperate with this matter.

Thank You,

Contemporary Women's Care

Signature: _____ Date: _____

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Non-Compliant Patient Agreement

As of May 1, 2014 there has been a change to the scheduled appointment policy with all patients. Due to many no-shows and the complications of care that this can cause, it is now our office policy to terminate the physician/patient relationship if the provider deems a patient non-compliant. This determination can be made due to a patient's refusal to cooperate with treatment or a patient's inability to keep follow up appointments. After a patient no-shows to scheduled appointments, a follow up call is made by our office in an attempt to reschedule the appointment. After two no-shows to scheduled appointments, with no response to our attempt to reschedule, patients will receive a warning call that the physician is considering terminating the physician/patient relationship due to non-compliance. If the patient does not respond, or still does not comply with the recommended care, they will receive a termination letter detailing the reason for termination. After a patient receives a Withdrawal of Care notice, they will have 30 days from the date of the notice to find other healthcare accommodations. By signing below, you are agreeing to the terms of the Non-Compliant Patient Agreement.

Patient Signature: _____ Date: _____

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Patient Consent for Use & Disclosure of Protected Health Information

With my consent Contemporary Women's Care may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations. (Please refer to Contemporary Women's Care Notice of Privacy Practices posted in the lobby for a more complete description of such uses and disclosures.)

With my consent Contemporary Women's Care may call my home or other designated locations and leave a message on my voicemail or answering machine, or in person, to any items that assist in the practice carrying out treatment, payment and healthcare operations, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent Contemporary Women's Care may mail to my home or other designated locations any items that assist in the practice carrying out treatment, payment and healthcare operations, such as appointment reminder cards and patient statements.

By signing this form, I am consenting to Contemporary Women's Care using and disclosing my PHI to carry out treatment, payment, and healthcare operations. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Contemporary Women's Care may decline to provide treatment.

Printed Name: _____ Legal Guardian: _____

Signature: _____ DOB: _____ Date: _____

If you are over the age of 21:

Dou you have advanced directives? (Living Will, Medical Power of Attorney) YES NO