Registration Form For Annual Exam

Please fill all the following information

Personal Information:

Patient Name: _____ **MI:** _____

Date of Birth: _____ **Marital Status:** _____ **SSN#:** _____

Mailing Address: _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Email Address: _____

Primary Doctor: _____ **Phone:** _____

Referring Doctor: _____ **Phone:** _____

Pharmacy: _____ **Phone:** _____

Ok to Leave Message at Home: Yes No **Ok to Leave Message at Work:** Yes No

Employment:

Employer Name: _____ **Phone:** _____

Address: _____

Emergency Contact:

Name: _____ **Relation:** _____ **Phone:** _____

Address: _____

Primary insurance:

Name: _____

Subscriber Name: _____ **DOB:** _____ **Relationship:** _____

Secondary insurance:

Name: _____

Subscriber Name: _____ **DOB:** _____ **Relationship:** _____

I hereby authorize the assignment of benefits (Payments) directly to Woman Care Clinic (Dr. Ammar Shammaa) for all my insurance claims related to services received. I agree to pay any and all charges that exceed, or are not covered by my insurance. I understand that co-pays, deductibles and non-covered services are due at the time of service. I authorize the release of any medical information necessary for the purpose of processing claims with my insurance company. I permit a copy of this authorization to be used in place of the original.

_____ _____

Patient's Signature (Parent's signature if under 18) Date

Woman Care Clinic

Ammar Shammaa, MD

Welcome to Dr. Ammar Shammaa office. This information is intended to help us with your care, please complete it as fully as possible

Chief Complaint:
What is the reason(s) for your visit today?
+ Annual Exam + Other (please specify): _____

Health Maintenance:
Last Pap smear: _____ Result _____ Place of the test _____

Last Mammogram: _____ Result _____ Place of the test _____

Last Bone Density: _____ Result _____ Place of the test _____

Last Colonoscopy: _____ Result _____ Place of the test _____

Do you use any type of hormones?
+ No + Yes: name of the medication _____

Gyn History:
Last menstrual period: _____ Menarche (first period in your life) at age of _____

I don't have periods because of: + Hysterectomy + Ablation (burning) + Menopause, at age of _____

If you are don't have periods move to the next section

Are your periods regular and normal? + Yes + No, describe _____

Do you have pain during your period? + No + Mild + Moderate + Severe

Do you use type of birth control? + No + Yes, what type _____

Have you had any abnormal Pap test? + No + Yes, treatment _____

Sexual History:
Are you sexually active? + No + Yes, one sexual partner + Yes, with multiple partners

Have you ever diagnose with any STD? + No + Gonorrhea + Chlamydia + HPV
+ Herpes + Syphlis + other _____

OB History:
Number of pregnancies (include abortion/miscarries/ectopic pregnancy) _____

Number of full term deliveries (after 37 weeks) _____

Number of preterm deliveries (before 37 week) _____

Number of abortion/miscarries _____

Number of a live children now _____

Review of the system:
Do you have recently any of the following condition (Circle all what apply)

General:
Fever
Pelvic pain
Weight loss

HEENT:
Runny nose
Ear pain
Sore throat

Female system:
Vaginal bleeding
Vaginal discharge
Vaginal itching
Genital lesions
Hot flashes

Cardiology:
Chest pain
Palpitation

Breast:
Breast lump
Breast discharge
Breast skin change
Breast pain

Respiratory:
Shortness of breath
Wheezing
Cough

Urology:
Pain with urination
Frequent urination
Blood in urine

Neurology:
Headache
Blurry vision

Gastroenterology:
Nausea
Vomiting
Diarrhea
Constipation
Blood in stool

Psychology:
Anxiety
Depression

Endocrinology:
Heat intolerance
Cold intolerance

Derm:
Skin rash

Woman Care Clinic

Ammar Shammaa, MD
4803 Kentucky Street
S. Charleston, WV 25309
Phone: (304) 766-9600

STD SCREENING

It is recommended by the American College of OB/GYN that all sexually active women under 25 years of age and all women 25 and older with risk factors such as high risk partners, multiple partners, or recent new partner be tested annually for **Gonorrhea and Chlamydia**. These tests will be performed during your annual examination and billed to your insurance. However, some insurance companies DO NOT reimburse for these tests and you may be responsible for the balance. If this is your situation, the lab will bill you only of the amount your insurance allows.

I fully understand that I may be billed by the lab company for the Gonorrhea and Chlamydia testing performed at Woman Care Clinic, INC.

☐ I wish to have the Gonorrhea and Chlamydia test

☐ I decline the Gonorrhea and Chlamydia test

_____ _____

Patient Signature Patient Name (please print)

_____

Witness

_____

Date

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HUMAN PAPILLOMA VIRUS SCREENING

We offer our patients a FDA-approved high-risk HPV test. This test is a highly sensitive viral test used in conjunction with a Pap test for cervical cancer screening in women aged 30 and older. Persistent infection with high-risk human papilloma virus (HPV) is the primary cause of cervical cancer. A few important things to know about HPV and cervical cancer screening:

- Most women will have HPV at some point during their lives but very few will develop cervical cancer.
- Cervical cancer develops if an HPV infection persists for many years.
- The Pap test looks for abnormal cell changes on the cervix that occur as a result of a persistent high-risk HPV infection. The HPV test looks for an HPV infection.
- When used together, these tests can show with nearly 100% certainty that you do not have cervical disease. Women, who test negative for high-risk HPV, and have a normal Pap test, have virtually no risk of developing cervical cancer before their next scheduled visit
- Early detection of pre-cancerous cell changes is the key to preventing cervical cancer.
- Your HPV status is not a reliable indicator of you or your partner's sexual behavior. HPV can lie dormant in cervical cells for many years before becoming an active infection.

Most insurance companies cover the high-risk HPV test when used with a Pap test for cervical cancer screening of women 30 or older. However the individual benefits you or your employer purchased may or may not cover the test. If the test is not paid for by your insurance company, you will receive a bill from the laboratory. Please ask your provider for the approximate cost of the HPV test.

Unfortunately Medicare, TriCare and Mail Handlers insurances do not cover HPV screening. Patients will be responsible for the expense of test.

☐ I have read the above information and **AGREE** to have the HPV test with my Pap test. I also agree to pay for the HPV test should my insurance not cover the cost.

☐ I have read the above information and **DO NOT** wish to have the HPV test at this time.

_____ _____

Patient Signature Patient Name (please print)

_____

Date

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FINANCIAL POLICY

It is our firm belief that all patients who come to all office deserve the finest medical care that can be provided. In order for us to provide you with high quality medical care, we must insure that we are able to meet our expenses. Our prime purpose in giving you this sheet to inform you with our financial policy before providing you with medical services

1- It is important to remember that your insurance is a contract between you and your insurer. Although we file insurance claims as a courtesy to you, you are still responsible for payment of services regardless of the amount your insurance pays

2- We will gladly bill your insurance for all office visits. However, we ask that you pay any portion not covered by insurance due to deductibles, or co-insurance **on the day of your visit**

3- We charge **$2.99 Statement Processing Fee** with every monthly statement we send, this is to cover the charges of the outsource company who prepare and send out our statements. We encourage you to avoid this charge by paying your co-pay and deductible at the time of service

4- All balances are due within 30 days, unless special arrangements have been made in advance. Payment can be made with cash, check or credit card

5- If after 90 days, you have not made proper payment arrangements, we may place the account with a collection agency. We do prefer to work out payment arrangements in our office, and only use collection agencies as a last resort

You signature constitutes an agreement ot this policy. If you have any questions, please feel free to ask our receptionist

_____ _____

Patient Signature Patient Name (please print)

_____

Date

Woman Care clinic, INC

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW OUR CAN GET ACCESS TO THIS IFORMATION
PLEASE REVIEW IT CAREFULLY
THE PRIVACY OF YOUR HEALETH INFORMATION IS IMPORTANT TO US

We understand that your health information is personal; we committed to protect this information. This notice applies to all of the records maintained by the Woman Care Clinic INC., your other health care providers, such as your personal doctor, may have different policies or notices regarding the use and disclosure of your protected health information.

OUR LEGAL DUTY:

We are required by applicable federal and state law to:

- Safeguard and maintain the privacy of your health information
- Give you this notice about our privacy practices, our legal duties and your rights concerning your health information
- Follow the terms of this notice as currently in effect

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective of all health information that we maintain, including health information we created or receive before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

USE AND DISCLOSE OF YOUR HEALTH INFORMATION:

The following categories describe different ways that we "use" and "disclose" your protected health information. For purposes of this notice, the term "use" refers to protected health information that is used within the Provider for your treatment, the provider's operations, or the payment of your care. The term "disclose" refers to protected health information that is given to outside entities for one of the purposes described in this notice. The term "may" means that the Provider is permitted under federal law to use or disclose this information without obtaining an additional or specific authorization from you to do so.

Even though the Provider may be permitted to use or disclose information in a given instance, it does not mean that we will use or disclose the information. We will still try to assure that any use or disclosure is in your interest or is consistent with practices in the health care field.

Treatment: We may use and disclose your health information to a physician or other health care provider who are involved in your medical care. Different departments may also share protected health information about you in order to coordinate the different things you need

Payment: We may use and disclose your health information to obtain payment of services we provide to you

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence of qualifications of healthcare professionals, evaluation practitioner and provider performance, conduction training programs, accreditation, certification, licensing, or credentialing activities

Your Authorization: in addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclosed your health information for any reason except those described in this Notice

To your family and friends: we must disclose your health inflammation to you, as described in Patient's Rights section of this Notice. We may disclose your health inflammation to a family member, friend or other person to the extent necessary to help with your healthcare, but only if you agree that we may do so

Persons Involved In Care: we may use or disclose your health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative, or another person responsible for your care, of your location, your general condition or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such use or disclosure. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescription, medical supplies, x-rays or other similar forms of health information

Marketing health related services: we will not use you health information for marketing without your written authorization

Required by law: we may use or disclose your health information when we are required to do so by federal, state or local law

Abuse or neglect: we may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National security: we may disclose to military authorities the health information of Armed Forces personnel under certain circumstances, we may disclose to authorize federal official health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement officials having lawful custody of protected health information of inmates or patient under certain circumstances

Appointment Reminders: we may use of disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards or letters)

Treatment Alternatives, Health-Related Benefits and Services: We may use and disclose your health information to tell you about or recommend possible treatment options or alternatives, health-related benefits or services that may be of interest to you.

Transfers: We may use and disclose information about you to another Provider to which you are being transferred or which is considering you as a transfer

Health Oversight Activities: We may disclose protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections and licensure. The federal government has determined that it must have access to this information to adequately monitor beneficiary eligibility for government programs (for example, Medicare or Medicaid), compliance with program standards and/or civil rights laws.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose protected health information about you in response to a court or administrative order. We may also disclose protected health information about you in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute

PATIENTS RIGHTS:

- Access: you have the right to look at or get a copy of your health information with limited exceptions. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by calling our office. We will charge you a reasonable cost-based fee expenses such as copies and staff time
- Restriction: you have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency)
- Alternative communication: you have the right to request that we communicate with you about your health information by alternative means or to alternative location. (You must make your request in writing). Your request must specify the alternative means or location.
- Right to a Paper Copy of This Notice: you have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time

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NOTICE OF PRIVACY PRACTICES

I _____ acknowledge that I have received a copy of The Woman Care Clinic, INC. Notice of Privacy Practices.

_____ _____

Patient Signature Patient Name (please print)

_____

Date