Registration Form For New Pregnant Patient

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? _____

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

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 _____

Current Medication:
Please list all your medications, include vitamins, over the counter medications and herbs

Name _____ strength_____ how often_____

Name _____ strength_____ how often_____

Name _____ strength_____ how often_____

Medical history:
Have you had or recently has any of the following condition?

+ Anemia + Blood transfusion + Diabetes + High blood pressure

+ Depression / Anxiety + Other, please specify: _____

Allergies:
Please list all your allergies: _____

Surgery History:
List all your surgeries: _____

Family History:
History of birth defect, blood clots or heart condition in close family member is very important to protect you from similar condition. Other conditions are also important, such as: Diabetes, Hypertension, Heart attack

Family member: _____ Condition: _____

Family member: _____ Condition: _____

Family member: _____ Condition: _____

Family member: _____ Condition: _____

Social History:
Do you smoke? + No + Yes drink Alcohol? + No + Yes use illegal drugs? + No + Yes

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

HIV/AIDS SCREENING TEST

Introduction:
Human immunodeficiency virus (HIV) is the cause of acquired immunodeficiency syndrome (AIDS). All persons infected with HIV can spread it to others through unprotected sex, needle sharing, and donating Blood or other tissues. Infected mothers can also spread HIV to newborns. Testing for HIV infection is voluntary, read this sheet carefully to help you decide whether to be tested or not.

What the test means:
The test detects antibodies to HIV (the body's reaction to the virus), not the virus itself.
A Positive test means that a person is infected with HIV and can pass it to others. By itself, a positive test does not mean that a person has AIDS, which is the most advanced stage of HIV.
A Negative test means that antibodies to HIV were not detected. This usually means that the person is not infected with HIV. In some cases, however, the infection may have happened too recently for the test to turn positive. The Blood test usually turns positive within 1 month after infection and in almost all cases within 3 months. Therefore, if you were infected very recently, a negative test result could be wrong.
False results (a negative test in someone who is infected, or a positive test in someone who is not infected) are rare. Indeterminate results (when it is unclear whether the test is positive or negative) also are rare. When a test result does not seem to make sense, a repeat test or special confirmatory tests may help to determine whether a person is or is not infected.

Benefits of being tested:
There are substantial benefits to being tested. Most infected persons may benefit from medications that delay or prevent AIDS and other serious infections. Test results also can help people make choices about contraception or pregnancy. Therefore, all infected persons should have a complete medical checkup, including tests of the immune system, to help their health care providers recommend the best health care.
There are other reasons to be tested. Even though everyone should follow safer sex guidelines whether or not they are infected with HIV, many persons find that knowing their test results helps them to protect their partners and themselves. Some persons want to know their test results before beginning a new sexual relationship or becoming pregnant. Others will be reassured by learning that they are not infected.

Privacy and confidentiality:
We will not disclose your result to others unless you direct us to do so or the law authorizes ask us to do so. Please review our complete HIPAA Notice (copy available upon request)

IF YOU HAVE ANY FURTHER QUESTION, PLEASE ASK TO SEE THE PHYSICIAN, HE WILL BE HAPPY TO ANSWER ANY QUESTION OR CONCERN

Woman Care Clinic

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

CONSENT for HIV SCREENING TEST

I have read and understand the HIV information that given to me. I have been advised of the nature of the HIV Blood test; what the results would mean; and the benefits and risks of being tested. I understand that I have the alternative of not being tested. I hereby authorize Woman Care Clinic, INC. and Dr. Ammar Shammaa to perform this test and to release the results to me.

☐ I wish to have the HIV test

☐ I decline the HIV test

_____ _____

Patient Signature Patient Name (please print)

_____

Witness

_____

Date

Woman Care Clinic

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

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

Woman Care Clinic

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

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

Dr. Ammar Shammaa

Obstetrics & Gynecology

4803 Kentucky Street

South Charleston, WV 25309

Phone: (304)-766-9600

Fax: (304)-766-9606

SUBSTANCE ABUSE TREATMENT PROGRAM

Substance Abuse Treatment Agreement

I understand that I am being prescribed a medication that will cause drug dependency and can be easily misused and overused. I freely and voluntarily agree to accept and abide by this treatment agreement. To help reduce my risk of harm from this medication I agree to the following rules.

1. I understand that there are alternatives to Buprenorphine treatment for opioid addiction including:

    a. Medical withdrawal and drug free treatment; and

    b. Methadone treatment

2. My physician has discussed with me the risks and benefits of the alternative treatments for opioid addiction in pregnancy, and has explained that methadone treatment is the most widely used and studied opioid addiction treatment during pregnancy. My physician also has explained to me that buprenorphine treatment for opioid addiction in pregnancy has not been as thoroughly studied as methadone treatment and that there might be unexpected adverse effects of buprenorphine treatment. My physician has explained to me that many medications used during pregnancy, including methadone and buprenorphine during pregnancy, carry risks including risks of death of mother and fetus. My physician has answered any questions I had about the treatment alternatives. After considering all that information, I have freely decided to undergo buprenorphine treatment while I am pregnant instead of other treatments, and I freely consent to buprenorphine treatment.

3. I agree to report my history and symptoms honestly. I will be honest and open about cravings and potential for relapse and about any relapse that has occurred **before** a drug test result shows it.

4. I agree to see my Buprenorphine provider on a regular basis and **be on time** to all of my scheduled appointments. The frequency of visits will be up to my Buprenorphine provider and will be explained to me. I agree to let Dr. Ammar Shammaa's office staff know if I will be unable to come for any appointment as scheduled.

5. It has been explained to me that Dr. Ammar Shammaa's office complies with all insurance requirements; however does not accept cash payment for services rendered in pertaining to the Substance Abuse Treatment Program.

6. I agree to conduct myself in a courteous manner in Dr. Ammar Shammaa's office. I agree not to deal, steal or conduct any other illegal or disruptive activities.

7. I agree not to arrive at Dr. Ammar Shammaa's office intoxicated or under the influence of drugs. I understand that, if I do, I will not be seen for my appointment and I will not be given any medication until

my next scheduled appointment and only if I come to that next appointment sober and not under the influence of drugs. I agree to abstain from alcohol, opioids, marijuana, cocaine, and other addictive substances, not including nicotine.

8. I agree not to sell, share, or give any of my medication to another individual. I understand that such mishandling of my medications is a serious violation of this agreement and will result in immediate termination of the Substance Abuse Treatment Program.

9. I understand my Buprenorphine provider will monitor my medication compliance by counting my medication. I agree to bring my Buprenorphine medication to **each office visit**.

10. I agree that prescriptions for my medications will be given to me only during my regular office visits. Buprenorphine will be prescribed in quantities to last from visit to visit, therefore any missed office appointments will result in my not being able to get that medication until the next scheduled visit, and only if I am complying with this agreement.

11. I agree to submit to periodic and random urine, blood, or mouth swab drug screens to detect early relapse and document my progress treatment. I understand that if I am unable to arrive in the office when requested upon for random drug screen I may be discharged from the Substance Abuse Treatment Program.

12. I agree that the medication I receive is my responsibility and that I will keep it in a safe, secure place where it cannot be taken accidently by children, pets, or taken by unauthorized users. I understand and agree that if I report that my supply of buprenorphine has been lost or stolen, my physician is **not obligated** to provide me with make-up supplies. This means that if I run out of my medication it could result in my experiencing symptoms of opiate withdrawals which must be reported immediately to Dr. Ammar Shammaa or member of office staff.

13. I agree not to obtain medications from any physicians, pharmacists, or other sources without informing my physician at Dr. Ammar Shammaa's Substance Abuse Treatment Program. I understand that mixing buprenorphine with other medications, especially benzodiazepines, such as Valium (diazepam), Xanax (alprazolam), Librium (chlordiazepoxide), Ativan (lorazepam) and/or other drugs of abuse including alcohol, can be dangerous. **I also understand that a number of deaths have been reported in persons mixing buprenorphine with benzodiazepines.**

14. I agree to take my medication as prescribed at the dosage determined by my physician. I have been informed that buprenorphine should be placed under the tongue to dissolve and that it should never be injected or inhaled. I agree that I will take my prescribed Buprenorphine only at the times and in the amounts prescribed and **only under the tongue**.

15. If I alter or forge a prescription, sell or in any way distribute prescribed narcotics or other controlled medications, including Buprenorphine, to any other person, I understand that Dr. Ammar Shammaa will terminate my care immediately and will inform the pharmacy and legal authorities of this felony act.

16. I understand that medication alone is not sufficient treatment for my disease and I agree to participate in the required group and individual counseling during my treatment with Buprenorphine. I agree to seek additional counseling such as AA or NA meetings and to work on a program of recovery.

17. I understand that my treatment in this program will continue until 6 weeks after my baby is born and that, during that time, it is my full responsibility to find another program or facility to take over and continue my buprenorphine treatment beyond 6 weeks after my baby is born.

18. I understand that my Buprenorphine treatment may be discontinued and I may be discharged from the Substance Abuse Treatment Program if I violate this agreement in any way.

19. I understand that I may withdrawal from this agreement at any time, either verbally or in writing, but that my withdrawal from this agreement will result in my no longer being treated for opioid dependence from Dr. Ammar Shammaa's Substance Abuse Treatment Program. This agreement will last while I am being treated for opioid dependence in Dr. Ammar's Shammaa's Substance Abuse Treatment Program. I understand that my withdrawal from this agreement of termination of Buprenorphine treatment will not automatically result in my being dismissed from obstetrics care but that nothing in this agreement is intended to be a guarantee of continued obstetrics care.

20. I will provide the office with my current contact information, and will update that contact information as necessary. I will notify the office immediately in the event I change my address or phone number.

21. My provider has recommended that I obtain my Buprenorphine from a single pharmacy. I may only choose **one** of the following two pharmacies' listed below. The pharmacy I would like to designate and will be locked in to is: *(Please circle one)*

Bypass Pharmacy in South Charleston or **Beewell Pharmacy in South Charleston**

22. I have been given a copy of this agreement by request, and Dr. Ammar Shammaa's office Substance Abuse Treatment Program procedures have been explained, including hours of operation, office phone number and my responsibilities as a recipient of addiction treatment services.

_____ _____

Patient's Name (Printed) Date

_____ _____

Patient's Signature Date

_____ _____

Physician / Physician Assistant / Witness & Title Date

Dr. Ammar Shammaa

Obstetrics & Gynecology

4803 Kentucky Street
South Charleston, WV 25309
Phone: (304)-766-9600
Fax: (304)-766-9606

Appendix A

1. I (name of patient) _____

2. Authorize Dr. Ammar Shammaa OB/GYN
3. To disclose any information needed to confirm the validity of my prescription and for submission for payment for the prescription.
4. To the dispensing pharmacy (_____) to whom I present my prescription or to whom my prescription is called/sent/faxed, as well as to third party payers.
5. For the purpose of assuring the pharmacy of the validity of the prescription, so it can be legally dispensed, and for payment purposes.

6. Date (on which this consent is signed)

   _____

7. Signature of patient

   _____

8. Signature of parent or guardian (where required)

   _____

9. Signature of person authorized to sign in lieu of the patient (where required)

   _____

10. This consent is subject to revocation at any time except to the extent that the program which is to make the disclosure has already taken action in reliance on it. If no previously revoked, this consent will terminate upon; (specify date, event, or condition, i.e. termination of treatment).

Notice to accompany disclosure:

Each disclosure made with the patient's written consent must be accompanied by the following written statement: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.