Laramie Physicians Women & Wellness Clinic

PATIENT INFORMATION

TODAY'S DATE:

First Name	Middle Name	Last Name	Date of Birth
Mailing Address	**City**	**State**	**Zip Code**
Physical Address	**City**	**State**	**Zip Code**
Primary Phone	Work Phone	Cell Phone	Patient Employer
Gender M F	Email Address	Social Security Number	
Spouse's Name (if applicable)		Marital Status Single Married Divorced Other Widowed	

OTHER INFORMATION

Patient's Primary Language: English Spanish Arabic Other

Patient's Ethnicity: Hispanic/Latino Not Hispanic/Latino Decline to Answer

Patient's Race: Black/African American Native American/Alaskan Native Native Hawaiian/ other Pacific Islander White Asian Other Decline to Answer

INSURANCE INFORMATION

Primary Insurance	Policy #	
Policy Holder Name	Date of Birth	Gender M F
Primary Holders Address		
Patient Relationship to Insured: Self	Spouse	Parent Other:_____
Secondary Insurance	Policy #	
Policy Holder Name	Date of Birth	Gender M F
Secondary Holders Address		
Patient Relationship to Insured: Self	Spouse	Parent Other:_____

APPROVED CONTACTS

In case of emergency, who should be notified? _____

Relationship:_____ Phone:_____

Do you give our office permission to discuss your medical information with anyone other than you, including lab/test results, appointments, and financial information? Yes No

Disclose to: _____ Phone: _____

Disclose to: _____ Phone: _____

Do you authorize our office to leave a detailed Voicemail/ Text Message / or Email, including lab/test results, appointments, and financial information, to patient's phone? Yes No Phone: _____

Signature: _____Date:_____

LARAMIE PHYSICIANS WOMEN & WELLNESS CLINIC

Thank you for choosing Laramie Physicians Women & Wellness Clinic. We are committed to providing you with quality and affordable health care. Our practice financial policy is as follows:

1. Insurance. LPWWC contracts with most major insurance companies, with Wyoming Medicaid and Medicare, and with selected other qualified third-party payment sources. However, LPWWC does not contract with all third-party payers.

a. If you are insured by a plan LPWWC contracts with, you will be expected to pay your entire co-payment, an estimate of your deductible or the co- insurance portion of your charges **on the day of service**. Co-payments, co-insurance and deductibles are part of your contract with your insurer. LPWC will file an insurance claim directly to your insurance company.

b. Payments collected at the time of services are *ESTIMATES* based on the information available to LPWWC at that time. If there is an additional balance due after your insurance has paid, then the balance will be your responsibility. Payment in full is due upon receipt of a billing statement.

c. Patients with out-of-network insurance will be treated as self-pay and should expect to pay in full for all services on the date of their appointment.

d. Knowing your insurance benefits is your responsibility. Contact your insurance company directly for any questions regarding your coverage.

Initials: _____

2. Coverage changes. If your insurance changes, please notify us as soon as possible so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 90 days, the balance will be billed to you.

3. Payment at time of service. Patients will be required to pay in full at time of service. If patients are unable to pay at time of service they may need to meet with our billing office regarding payment options.

4. Non-covered services. Some and perhaps all of the services received may not be covered by your insurance or not considered reasonable or necessary by your insurer. "Non-covered" may become your financial responsibility and payment in full for these services is generally due at each visit.

5. Nonpayment. If you have not made payments to your account and if there has been no attempt to contact our office with financial arrangements, it may be assigned to a collection agency after 90 days of no payment on account.

6. Payment plans. Contact one of our Billing Specialists if you need to review your financial status or make payment arrangements.

7. Payment Methods. LPWWC accepts payments via cash, check, Master Card, Visa, Discover Card, and Care Credit. Payments can also be made online at **Laramiephysicians.com/our-office/billing-insurance**

8. Late Appointments. In an effort to keep our providers schedules running on time and to reduce wait times we ask that patients arrive on time for their appointment. Patients arriving more than 10 minutes late may be asked to reschedule.

9. Missed Appointments. In order to accommodate all patients LPWWC may assess a missed appointment fee. Please call within 24 hours of your appointment to cancel/reschedule in order to open that time slot for other patients.

10. Returned checks (NSF). You will be charged a $35.00 processing fee for any personal check returned for nonpayment.

By signing this form you authorize LPWWC to release the necessary information in order to complete and process your insurance claims. I have read and understand the payment policy and agree to abide by its guidelines.

Signature of patient or responsible party: Date:

_____ _____

Notice of Privacy Practices Acknowledgment

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:

Laramie Physicians Women & Wellness Clinic

Date: _____

Women's Health History

Name:_____ Date of Birth:_____ Age:_____ Weight:_____

Do you have any personal or religious objections to treatment or vaccinations? **Yes** **No**

If yes, please explain: _____

Current Prescription Medications

Name	Dose	Frequency

PREFERRED PHARMACY:_____

Current "Over-the-counter" Medications (include Vitamins and Supplements)

Name	Dose	Frequency

Allergies (Food or Medication)

Drug Name	Reaction

Latex **Yes** **No** Iodine **Yes** **No** Food:_____

Other:_____

Menstrual History

What was the first day of your last period?_____

Describe the amount of menstrual flow: Light Moderate Heavy

How many days do you flow? _____ How often do your periods start? (i.e. every 28 days)_____

What age did you start your periods? Are you **still** menstruating? **Yes** **No**

QUESTION	YES	NO
Do you have painful periods?		
Do you have history of infertility?		
Do you have Endometriosis?		
Do you bleed between periods?		
Do you flow twice as much as you did 10 years ago?		
Do you have pain with intercourse?		
Do you have bleeding during or after intercourse?		

Child Bearing History

How many times have you been pregnant?_____

How many full term deliveries(37 weeks or greater)? Preterm Deliveries(<37 weeks)? Multiple Births(i.e. twins)?

_____

How many live births?_____ Vaginal Birth?_____ Cesarean Birth?_____

How many miscarriages?_____ Abortions?_____ Ectopic?_____

How many living children?_____ Adopted?_____

Deceased children?_____ Stillborn?_____

GYN History

When was your last pap smear? _____ Was it normal? **Yes** **No**
Have you ever had an abnormal pap smear? **Yes** **No**
Have you ever had a procedure for an abnormal pap smear? **Yes** **No**
If YES, which procedure? _____When?_____
How many sexual partners have you had in your lifetime? _____
Have your sexual partners been: Men Women Both
Have you ever tested positive for any sexually transmitted diseases? **Yes** **No**
If YES, which STD(s)? _____ Treatment?_____ When?_____
Please circle the method(s) of contraception you're currently using:
Pill Condoms Rhythm Hysterectomy Tubal Vasectomy Nexplanon IUD Depo Withdrawal Nuva Ring None

Are you currently taking female hormones? **Yes** **No** Which ones?_____
Do you have symptoms of menopause? **Yes** **No**
Painful intercourse Irritability Hot flashes Mood changes Vaginal dryness Insomnia Night sweats

QUESTION	YES	NO	WHEN
Do you examine your breasts monthly?			
Do you have breast implants?			
Have you had a mammogram?			
Have you had an abnormal mammogram?			
Have you ever had a breast biopsy?			

Do you lose urine when you cough or sneeze? **Yes** **No** If yes, do you have to wear a pad? **Yes** **No**

Medical History

Have you ever been hospitalized? **Yes** **No** If YES, please list date(s) and reason(s) below
_____
_____
_____
Serious Injuries/Accidents? **Yes** **No** If YES, please list date(s) and reason(s) below
_____
_____
Infections? **Yes** **No** If YES, please list date(s) and reason(s) below
_____
_____

Do you have any CHRONIC Illnesses? Ex: (Thyroid disorder, Epilepsy, Cancer, High Blood Pressure)
_____
_____
_____

Surgical History

Date **Surgery:** **Facility:** **Reason:** **Complications?**
_____
_____
_____
_____

Social History- Continued on next page

Question	Yes	No	How Often?	How Long?
Are you Sexually Active?				
Do you Smoke/Vape or E-Cig/Chew?				
Do you Drink Alcohol?				
Do you use Illicit Drugs (Current or Past)				
Domestic Abuse (Verbal and/or Physical)				

Marital Status: Married Single Widowed Divorced Separated
Occupation:_____ Employer:_____Hours/week:_____
Stress Level: Low Moderate High
Diet: Balanced Low Sugar Low Salt No particular Other:_____
Exercise: Minimal Regular Very active
Seat Belt: Always Never Most of the time

Family History

Circle if anyone in your family (parents, siblings, grandparents, etc.) had/has any of the following:

Question	Yes	No	Who	Mother's or Father's Family?	Are they still alive?
Diabetes?					
Muscle/Osteoporosis					
Alzheimer's/Dementia					
High Blood Pressure					
Stroke					
Heart Disease					
Lung Cancer					
Breast Cancer					
Cancer(Any Other):					
Other:					

Clinical Testing

Question	Yes	No	When
Have you ever had your wellness labs drawn?			
Have you ever had a bone density test?			
Have you ever had a Colonoscopy?/Cologuard Test			
Have your Thyroid tested in the past year?			
Have you had a TDAP Vaccine?			
Have you had a Hepatitis B Vaccine?			
Have you had a Flu Vaccine?			
Have you had the Gardasil (HPV) Vaccine?			
Have you had the COVID-19 Vaccine?			
When was your last dental exam?			

Additional Comments:

_____
_____
_____
_____
_____

LPWWC Staff Initials/ Date