

# Laramie Physicians for Women and Children

## 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

<b>Primary Insurance</b>	Policy #		
Policy Holder Name	Date of Birth	Gender    M    F	
Primary Holders Address			
Patient Relationship to Insured:	Self	Spouse	Parent      Other: _____
<b>Secondary Insurance</b>	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 FOR WOMEN & CHILDREN PAYMENT POLICY

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

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

**a.** If you are insured by a plan LPWC 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 LPWC 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.** LPWC 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](https://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 LPWC 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 LPWC 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 for Women and Children
Women's Health History

Today's Date: \_\_\_\_\_

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: Y N Iodine: Y N 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
Do you have painful periods? Yes No
Do you have history of infertility? Yes No
Do you have endometriosis? Yes No
Do you bleed between periods? Yes No
Do you flow twice as much as you did 10 years ago? Yes No
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? # Cesarean?
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 Neplanon IUD Depo Withdrawal Nuva Ring None
Are you currently taking female hormones? Yes No Which ones?
Do you have symptoms of menopause?
Painful intercourse Irritability Hot flashes Mood changes Vaginal dryness Insomnia Night sweats
Do you examine your breasts monthly? Yes No
Do you have breast implants? Yes No When?

Have you had a mammogram? Yes No When?  
 Have you had an abnormal mammogram? Yes No When?  
 Have you ever had a breast biopsy? Yes No When?  
 Do you lose urine when you cough or sneeze? Yes No If yes, do you have to wear a pad? Yes No

**Medical History**

Hospitalizations:

Date: Reason:  
 \_\_\_\_\_  
 \_\_\_\_\_

**Chronic Illness: Thyroid Disorder Endometriosis Epilepsy Cancer (Kind)**

**Other:**

Serious Injuries/Accidents:

Date: Type:  
 \_\_\_\_\_  
 \_\_\_\_\_

Infections:

Type: When: Treatment:  
 \_\_\_\_\_  
 \_\_\_\_\_

**Surgical History (Hyst?)**

**Date: Surgery: Surgeon: Facility: Reason: Complications:**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Social History**

Sexually Active? Yes No  
 Marital Status: Married Single Widowed Divorced Separated  
 Occupation: 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  
 Smoke/Vapor or Ecig/chew Yes No How often: How long:  
 Alcohol: Yes No How often: How long:  
 Illicit Drugs: Yes No How often: How long:  
 Domestic Abuse: Yes No How often: How long:

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

Diabetes:	Yes	No	Who?	Mother/Fathers family?	Alive?	Y	N
Muscle/Osteoporosis:	Yes	No	Who?	Mother/Fathers family?	Alive?	Y	N
Mental/Alzheimers:	Yes	No	Who?	Mother/Fathers family?	Alive?	Y	N
High blood pressure:	Yes	No	Who?	Mother/Fathers family?	Alive?	Y	N
Stroke:	Yes	No	Who?	Mother/Fathers family?	Alive?	Y	N
Heart disease:	Yes	No	Who?	Mother/Fathers family?	Alive?	Y	N
Lung disease:	Yes	No	Who?	Mother/Fathers family?	Alive?	Y	N
Cancer: Type:	Yes	No	Who?	Mother/Fathers family?	Alive?	Y	N
Other:	Yes	No	Who?	Mother/Fathers family?	Alive?	Y	N

**Clinical Dates**

Have you ever had your wellness labs drawn? Yes No When?  
 Have you ever had a bone density test? Yes No When?  
 Have you ever had a colonoscopy? Yes No When?  
 Have you had a thyroid test within the past year? Yes No When?  
 Have you had a TDAP immunization? Yes No When?  
 Have you had a Hepatitis B Immunization? Yes No When?  
 Have you had a Flu Vaccine? Yes No When?  
 Have you had the HPV/ Gardasil Vaccine? Yes No When?

**Additional Comments:** \_\_\_\_\_  
 \_\_\_\_\_

**CNA initials / date:**