

Patient Financial Disclosure

The following information is provided to all of our patients, new and established, to inform patients of our office financial policies and of patient financial responsibility requirements. Please ask one of our team members if you have any questions regarding these policies.

*We will be happy to bill your insurance as a courtesy; however, all charges, regardless of insurance coverage are the patient's responsibility. **We do expect payment for your portion at the time of service. (co-pays, co-insurance, deductibles). We ask that if your insurance has not paid within 45 days that you follow up with them. Our office contracts with most insurance carriers.**

*If you are seen for both wellness or an annual exam and an illness of separate problem is also addressed, proper coding will be used which may result in a charge for both services. Additionally, some medically indicated lab work may *not* be covered by all wellness policies. Your individual contract with your insurance carrier will determine how your insurance will pay. We make every effort to bill each visit with the proper diagnosis and procedure codes according to national coding guidelines. Please understand that we cannot make exceptions to our coding practices due to federal and state legal compliance concerns, and we are unable to bill for services other than those documented in your medical record.

*Injections and some medical supplies must be paid for in advance at the time of service. Lupron injection, Mirena, Paragard, Implanon and other specialized products or services must be pre-authorized with insurance *prior* to service; otherwise, these services will need to be paid in full by the patient at the time of service.

*For surgical care, we will pre-certify your insurance and obtain the estimated patient responsibility for the procedure. This amount is due prior to the scheduled date of surgery. If the procedure results in additional charges, these fees will be billed to you. We would ask that you pay the balance within 30 days following your surgery. Acceptable payment includes cash, check, VISA, MasterCard or CareCredit.

*We routinely send our PAP and laboratory testing to Laboratory Corporation of America (LabCorp). Some unique Obstetrical testing may be sent to Diagnostic Laboratory of Oklahoma (DLO). Our pathology testing is referred to Heartland Pathology, PC. You will receive separate invoices from them. These providers may or may not participate with your health plan. You may request that we refer your testing to another location. This request will need to be done with *each* visit.

*It is necessary to strictly enforce the policy of financial obligation. All co-pays, patient self-payment, and estimated care patient financial responsibility may be paid by cash, check, VISA, Mastercard or Care Credit. Only additional fees will be invoiced by the office to the patient. These are due within 30 days of receipt of invoice.

*There may be a charge for a no show of less than 24 hour cancellation (business hours) of \$25.00. This fee is the responsibility of the patient and cannot be filed with insurance companies. Cancellation messages must be made with the office during regular business hours and cannot be made with the after-hours answering service in an effort to avoid this charge.

*Paperwork (for example Family Medical Leave Act (FMLA) & Short Term Disability applications) will be completed within a week of presentation. The charge for each form is \$20, payable in full at the time the form is left for completion.

*Finance charges will accrue on balances over 60 days at a rate of 1.5% per month (18% per annum).

I have read and understand the above information and agree to comply with these financial policies.

Signature: _____ Print Name: _____ Date: _____

PATIENT DEMOGRAPHIC FORM

(THIS FORM IS TO BE UPDATED YEARLY **AND** WITH ANY INFORMATION CHANGES)

Patient Name: _____ SS#: _____ - _____ - _____

Date of Birth: _____ SEX: M ___ F ___ Marital Status: S ___ M ___ D ___ W ___

Address: _____ Apt. No.: _____

City: _____ State _____ Zip Code: _____

Primary phone: (_____) _____ Secondary Phone :(_____) _____

Mobile phone: (_____) _____ Email _____

Emergency Contact Name: _____ **Phone:** (_____) _____

Referring Physician: _____ Phone (_____) _____

Address _____ City _____ State _____ Zip _____

RESPONSIBLE PARTY:

Name: _____ SS#: _____ - _____ - _____

(Last) (First) (Middle)

Relationship to Patient: _____ Date of Birth: _____

Address: _____ Apt. No.: _____

City: _____ State _____ Zip Code: _____

Home phone: (_____) _____ Cell:(_____) _____

I hereby authorize care of my minor child (under 18 yr of age)

Parent or Legal Guardian Name: _____ Signature: _____ Date: _____

PATIENT'S INSURANCE INFORMATION: *Please provide Insurance Card and Photo ID to Receptionist

Primary Insurance Name: _____

Insurance Address: _____

City: _____ State _____ Zip Code: _____ Phone Number (_____) _____

Name of Policy Holder: _____ Date of Birth: _____

Insurance ID Number: _____ Group Number: _____

Employer's Name: _____ Wk Phone: (_____) _____

Employer's Address: City: _____ State _____ Zip Code: _____

Secondary Insurance Name: _____

Insurance Address: _____

City: _____ State _____ Zip Code: _____ Phone Number (_____) _____

Name of Policy Holder: _____ Date of Birth: _____

Insurance ID Number: _____ Group Number: _____

Employer's Name: _____ Wk Phone: (_____) _____

Employer's Address: City: _____ State _____ Zip Code: _____

READ AND SIGN:

I hereby authorize my insurance benefits to be paid directly to ***Champion Women's Health Specialists, PC.***

I understand I am responsible for all charges including my added costs incurred due any effort to collect for services rendered. I realize I am responsible to pay for services not covered by my insurance. I hereby authorize the release of pertinent medical information to insurance carriers.

Signature of Responsible Party: _____ Date: _____

NOTICE OF PRIVACY PRACTICES of Champion Women's Health Specialists

You may keep a copy of this notice. You must complete the information on the "PATIENT PRIVACY PRACTICES ACKNOWLEDGEMENT" page and return to our office to be kept in your medical record. The following notice describes how your medical information may be used and disclosed and how you can get access to this information. Please review it carefully.

Champion Women's Health Specialists, PC (CWHS) is required to maintain the privacy of your health information and provide you with a notice of its legal duties and privacy practices. We call this information "protected health information" or "PHI". We will not use or disclose your PHI except as described in this notice. With some exceptions, we may not use or disclose any more of your PHI than is necessary to accomplish the purpose of the use or disclosure. This notice applies to all PHI generated or maintained by us. Your PHI shall be maintained in electronic format.

TREATMENT, PAYMENT & HEALTHCARE OPERATIONS

Treatment: We may use your PHI to provide you with medical treatment and services. We may disclose your PHI to healthcare personnel who need to know your PHI for your care and continued treatment. Different resources may share your PHI in order to coordinate services. We may use and disclose your PHI to tell you about or to arrange for treatment options for your continued care after you leave CWHS.

Payment: We may use and disclose your PHI for the purpose of determining coverage, billing, collections, claims management, medical data processing, and reimbursement. PHI may be released to an insurance company, third party payer or other entity (or their authorized representatives) involved in the payment of your medical bill and may include copies or excerpts of your medical record that are necessary for payment of your account. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or determine whether your plan will cover treatment.

Routine Healthcare Operations: We may use and disclose your PHI during routine healthcare operations. These uses and disclosures are necessary to run the practice and make certain our patients receive quality care.

SPECIAL CIRCUMSTANCES

Emergencies: Your authorization is not required if you need emergency treatment.

OTHER USES AND DISCLOSURES

Family/friends: We will not disclose your PHI to any family member or friend IF YOU DO NOT AUTHORIZE US TO DO SO IN ADVANCE. However, we may disclose your PHI to anyone paying for your medical care. We may disclose your PHI to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location.

Appointment Reminders: We may use and disclose your PHI to contact you as a reminder that you have an appointment for treatment or medical care. This may be done through an automated system, by one of our staff members, or by mail. If you are not home, we may leave a message on an answering machine or with the person answering the telephone.

Health-Related Business and Services: We may use and disclose your PHI to tell you of health-related products, benefits or services related to your treatment, case management, care coordination, or alternative treatments, therapies, providers or care settings.

Business Associates: We may disclose your PHI to business associates with whom we contract to provide services on our behalf. We will only make these disclosures if we have received satisfactory assurance that the business associate will properly safeguard your PHI.

Limited Marketing Purposes: We may use your PHI to provide promotional items of nominal value or marketing information communicated to you face-to-face. For example, we may provide free baby products to new mothers.

Workers Compensation: We may disclose your PHI for workers' compensation or similar programs in order to comply with workers' compensation and similar laws.

Other uses: You must provide a separate authorization from to CWHS to use or disclose your PHI for situations not described in this NOTICE.

SPECIAL SITUATIONS

Regulatory Agencies: We may disclose your PHI to a health oversight agency for activities required or permitted by law including, but not limited to, licensure, certification, audits, investigations, inspections and medical device reporting. We may provide your PHI to assist the government when it conducts and investigation or inspection of a healthcare provider or organization.

Law Enforcement: We may disclose your PHI if asked to do so by law enforcement official: (i) in response to a court order, warrant, summons or other similar process; (ii) to identify or locate a suspect, fugitive, material witness, or missing person; (iii) about the victim of a crime, if under limited circumstances, we are unable to obtain the person's agreement; (iv) about a death we believe may be the result of criminal conduct; (v) about criminal conduct at the practice; and (vi) in emergency circumstances to report a crime, the location of a crime or victims, or the identity, description or location of the person who committed the crime.

Lawsuits and Disputes: If you are involved in a lawsuit or dispute, we may disclose your PHI in response to a valid court or administrative order. In limited circumstances, we may disclose PHI in response to a subpoena, discovery request or other lawful process, but only if efforts have been made to inform you about the request or to obtain an order protecting the information requested.

Public Health: As required or permitted by law, we may disclose your PHI to public health or legal authorities charged with preventing or controlling disease, injury or disability.

Judicial and Administrative Proceedings: We may disclose your PHI in the course of any administrative or judicial proceeding.

Specific Government Functions: We may disclose your PHI to military personnel and veterans in certain situations. We may disclose your PHI for national security purposes, such as protecting the president of the United States or conducting intelligence operations.

Military/Veterans: We may disclose your PHI as required by military command authorities, if you are a member of the armed forces.

Inmates: If you are an inmate of a correctional institute or under the custody of a law enforcement officer, we may release your PHI to the correctional institute or law enforcement official.

Health & Safety: In order to avoid a serious threat to the health and safety of a person or the public, we may disclose PHI to law enforcement personnel or persons able to prevent or lessen such harm. We may notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition as ordered by public health authorities or allowed by state law. The information authorized for release may include records which may indicate the presence of a communicable or

venereal disease which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and the human immune-deficiency virus.

PATIENT HEALTH INFORMATION RIGHTS

Although all records concerning your treatment at CWHS are the property of CWHS, you have the following rights concerning your PHI.

Right to Confidential Communications: You have the right to receive confidential communications of your PHI by alternative means or at alternative locations. For example, you may request that we only contact you at work or by mail. You must submit this request in writing.

Right to Inspect and Copy: You have the right to inspect and copy your PHI as provided by law. A request must be made in writing. We have the right to charge you the amounts allowed by state or federal law for such copies. We may deny your request to inspect and copy in certain circumstances. If you are denied access, you may request that the denial be reviewed. A licensed healthcare professional chosen by us will review your request and the denial and make the final determination.

Right to Amend: If you feel that the PHI we have about you is incorrect or incomplete, you have the right to request an amendment of your PHI. You must submit your request in writing and state the reason(s) for the amendment. We may deny your request for an amendment if it is not in writing, does not include a reason to support the request, or the information (i) was not created by us; (ii) is not part of the medical record that we maintain; (iii) is not part of the information that you would be permitted to inspect or copy; or (iv) is accurate and complete.

Right to an Accounting: You have the right to obtain a statement of certain disclosures of your PHI to third parties, except those disclosures made for treatment, payment or healthcare operations, authorized by you or pursuant to this Notice. To request this list, you must submit your request in writing and state a time period no longer than six (6) months, which may not include dates prior to May 1, 2007. If you request more than one (1) accounting in a 12-month period, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to modify or withdraw your request before any costs are incurred.

Right to Request Restrictions: You have the right to request restrictions or limitations on PHI we use or disclose about you unless our use or disclosure is required or permitted by law. We are not required to honor your request. Any agreement to additional restrictions must be in writing and signed by a person authorized to make such an agreement on our behalf. To request restrictions, you must make your request in writing and tell us (i) what information you want to limit; (ii) whether you want to limit our use, disclosure or both; and (iii) to whom you want the limits to apply. If we agree, we will comply with your request unless the information is needed to provide emergency treatment to you.

Right to Receive Copy of this Notice: You have the right to a paper copy of this notice.

CHANGES TO THIS NOTICE: We will abide by the terms of the notice currently in effect. We reserve the right to change the terms of its notice and to make the new notice provisions effective for all PHI we maintain. We will provide you with the revised Notice at your first visit following the revision of the Notice.

OWNERSHIP CHANGE: In the event that Champion Women's Health Specialists is sold or merged with another organization, your PHI may become property of the new owner.

NOTICE EFFECTIVE DATE: May 1, 2007; revised May 29, 2011.

FOR MORE INFORMATION OR TO REPORT A PROBLEM: If you have questions and would like additional information, or if you would like to report a problem with our privacy practices please contact CWHS, 3300 Northwest 56th Street, Suite 300, Oklahoma City, OK 73112, (405) 605.7757.

PATIENT PRIVACY PRACTICES ACKNOWLEDGEMENT

I authorize Champion Women’s Health Specialists, J. Todd Robinett, D.O., and Victoria Mills, D.O. to use my health information in the following ways. Please MARK your preference.

1. _____ DO NOT MAIL my PAP results sent to my home.
_____ I want my PAP results mailed to my home in a sealed confidential envelope.

2. As described in the NOTICE OF PRIVACY PRACTICES there are individuals and entities to which CWHS is legally authorized to disclose my health information.

In addition, I authorize the following individual(s) to have access to my health information:

Name

Street Address, City, State, Zip Code

Telephone Number(s)

Relationship to Patient

Patient Signature and Date

Description of Access Allowed:

Champion Women’s Health Specialists is committed to protecting your privacy and ensuring that your health information is used and disclosed appropriately. This Notice of Privacy Practices identifies all potential uses and disclosures of your health information by our practice and outlines your rights with regard to your health information. Please sign below to acknowledge that you have received a copy of the Notice of Privacy Practices.

I acknowledge that I have received a copy of the Notice of Privacy Practices of Champion Women’s Health Specialists.

Name of Patient (Printed): _____

Patient’s Signature: _____

Date: _____

Name of Personal Representative (if appropriate): _____

Signature of Personal Representative (if appropriate): _____ Date: _____



Victoria Mills, D.O. ◇ J. Todd Robinett, D.O.
 3300 Northwest 56th Street, Suite 300
 Oklahoma City, Oklahoma 73112
 Phone: 405.605.7757 ◇ Fax: 405.605.7911

Patient Health Information

Patient Name: _____ Age: _____

Birth Date: _____ Today's Date: _____

Preferred Pharmacy (name/location): _____

Primary Care Doctor or Family Doctor: _____

Other current doctors: _____

Please tell us how you heard about our office/doctors: _____

CURRENT FEMALE HEALTH HISTORY

When did your last menstrual period start? _____

Pregnancy History

Please give us information about all past pregnancies. If you have never been pregnant write NONE. Please include all pregnancies including miscarriages, abortions, and ectopic (tubal) pregnancies.

Date Delivered	# Weeks Preg	Birth Weight	Sex	Delivery Type	Complications

PRIMARY PROBLEM

What is the main reason for today's appointment? _____
Please give any details about your problem that may be helpful. If you have had tests or treatments for this problem by another doctor, clinic, hospital, or ER please provide those details below.

FEMALE HEALTH HISTORY

If you have now or have ever had ANY of the following problems, please note by circling all that apply.

- Endometriosis
- Uterine fibroids
- Pelvic pain
- Ovarian cysts
- Abnormal pap smear
- Cervical cancer
- Breast cancer
- Uterine cancer
- Ovarian cancer
- Infertility
- Abnormal bleeding
- Heavy or Frequent periods
- Osteoporosis or osteopenia
- Any other female health problems (specify):

Do you currently use birth control (includes ANY: pill, shot, patch, ring, tubes tied, vasectomy, condoms, etc)? _____ If yes, what type? _____

What types of birth control have you used in the past? _____

When was your last pap smear? _____

- What were the results?

- Have you ever had tests or treatment for abnormal pap smear? (please provide details) _____

FEMALE HEALTH HISTORY (continued)

Have you ever had any of the following sexually transmitted infections?

- Chlamydia yes/no
- Gonorrhea yes/no
- Trichomonas yes/no
- Syphilis yes/no
- Herpes yes/no
- HPV or genital warts yes/no

Have you ever received a vaccine to prevent Human Papillomavirus (HPV), cervical cancer, and genital warts (brand name Gardasil or Cervarix)? yes/no

- If "yes," did you finish the series of 3 injections? yes/no

Breast mammogram

- Date last performed, or "none": _____
- Results of last mammogram: _____

Bone mineral density (BMD) test

- Date last performed, or "none": _____
- Results of last BMD test: _____

Colonoscopy test

- Date last performed, or "none": _____
- Results of last colonoscopy: _____

GENERAL HEALTH HISTORY

If you have now or have ever had ANY of the following, please note by circling all that apply.

Chicken Pox	Asthma or other lung problem	Cancer type? _____	Diabetes
Blood clots in blood vessels (pe or dvt)	Heart problems	Hepatitis type? _____	High blood Pressure
High cholesterol	HIV/AIDS	Kidney problems	Stroke
Seizures	Anemia	Acid reflux (GERD)	Blood transfusion

Please provide any details about the above, or other disease history: _____

PAST SURGERY HISTORY

List ALL surgeries you have ever had. Please include the year and any related problems with recovery or complications.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

OTHER PERSONAL HEALTH INFORMATION

Marital status

- Are you married, divorced, or single? _____

Occupation

- What is your occupation? _____
- Do you have work-related health risks?
(if yes, please describe) _____

Habits

- Indicate below if you use any of these substances.
 - Caffeine yes/no how much: _____
 - Tobacco yes/no how much: _____
 - Alcohol yes/no how much: _____
 - Drugs yes/no
 - what kind & how much: _____

Legal

- Do you have any of the following?
 - Living will yes/no
 - Power of Attorney yes/no

FAMILY HEALTH HISTORY

If any of your blood relatives have any of the following health problems please circle below and indicate how you are related to the person.

- Arthritis, Gout Relative type: _____
- Asthma Relative type: _____
- Colon cancer Relative type: _____
- Breast cancer Relative type: _____
- Ovarian cancer Relative type: _____
- Other cancer (specify) Relative type: _____
- Chemical dependency Relative type: _____
- Diabetes Relative type: _____
- Heart disease/heart attack Relative type: _____
- Stroke Relative type: _____
- High blood pressure Relative type: _____
- Kidney disease Relative type: _____
- Hepatitis Relative type: _____
- Tuberculosis Relative type: _____
- Genetic conditions Relative type: _____
- Birth defects/mental retardation Relative type: _____
- Other (specify) Relative type: _____

ALLERGIES

Please indicate if you have allergy to latex, medications, foods or other substances and what kind of an allergic reaction you have to each:

MEDICATIONS

List ALL medications you take. Provide medication name, strength, how many & how often you take it. _____

ADDITIONAL

Please use the space below to provide any additional information you feel would be helpful or important for your appointment today.

PATIENT INITIALS: _____ I certify the above information is correct. I will not hold Champion Women's Health Specialists PC, my doctor, or any member(s) of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

PATIENT SIGNATURE: _____ **DATE:** _____

Family History Questionnaire for Common Hereditary Cancer Syndromes

Patient Name:

Date of Birth:

Today's Date:

Instructions: Please complete the following questionnaire. This will help your healthcare provider to determine if you are at risk for developing certain hereditary cancers. For "Yes" answers indicate relative type such as aunt, uncle, grandmother, etc.

COLON AND UTERINE CANCER		YOU	Mother's side	Father's side	Age at Diagnosis
YES NO	Uterine cancer BEFORE age 50				
YES NO	Colorectal cancer BEFORE age 50				
YES NO	Both Uterine and Colorectal cancer (in an individual or family)				
YES NO	Two or more Uterine or Colorectal (in an individual or family)				
YES NO	Ovarian cancer (in an individual or family)				
YES NO	Stomach, Kidney/urinary tract, Brain OR small bowel cancers (in an individual or family member)				
YES NO	Ten or more Colon polyps found in a lifetime				

BREAST AND OVARIAN CANCER		YOU	Mother's side	Father's side	Age at Diagnosis
YES NO	Breast cancer before age 50				
YES NO	Ovarian Cancer				
YES NO	Breast cancer in both breasts or multiple primary breast cancers				
YES NO	Both Breast and Ovarian cancer (in an individual or family)				
YES NO	Male breast cancer				
YES NO	Two or more breast or ovarian cancers (in an individual or family)				
YES NO	Ashkenazi Jewish ancestry AND a personal or family history of breast or ovarian cancer				

Please list any other cancers in your family:



Patient offered genetic testing: ACCEPTED DECLINED

Patient Signature

Print Name

Date