Lakeview Women's Health

Patient Information

Patient Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Date of Birth: _____ Age: _____

Marital Status: Married Single Widowed Divorced

Email Address: _____

Referred By / How did you hear about us: _____

Preferred Provider (Circle One): Heather Anderson, DNP, CNM / Cathy Hoover, WHNP

Responsible Party

Name: _____ Relationship: _____

Date of Birth: _____ Social Security Number: _____

Primary Insurance

Insurance: _____

Address: _____

Phone: _____ Fax: _____

Subscribers Name: _____ Date of Birth: _____

Relationship to Subscriber: _____ ID#: _____

Secondary Insurance

Insurance: _____

Address: _____

Phone: _____ Fax: _____

Subscribers Name: _____ Date of Birth: _____

Relationship to Subscriber: _____ ID#: _____

Reason for Today's Visit:

_____

When did you first notice the symptoms & **LAST MENSTRUAL PERIOD:**

_____

What treatment have you received:

_____

Name of the Doctor(s) that have treated you:

_____

Date of Last Mammogram: _____ Date of Last Pap: _____

Date of Last DEXA: _____ Date of Last Colonoscopy: _____

Flu Vaccine: _____ Shingles Vaccine: _____ Pneumonia Vaccine: _____

Social History

Exercise on a daily basis? None Moderate Heavy

Do you Smoke? Yes If Yes, Please Specify: _____ No Former

Do you drink Alcohol? Yes Drinks per week: _____ None

Has anyone ever told you to cut down on your drinking? Yes No

Do you use drugs for reasons that are not medical? Yes No

Family History

Father: Alive Deceased Age: _____ Medical History: _____

Mother: Alive Deceased Age: _____ Medical History: _____

Sister: Alive Deceased Age: _____ Medical History: _____

Brother: Alive Deceased Age: _____ Medical History: _____

Children: _____ Ages: _____ Medical History: _____

Surgical History

Have you had a Hysterectomy? Yes No If Yes, Why: _____

Surgery:	Date:	Reason:	Notes (If Any)
Births:	**Gender / Weight:**	**Date:**	**Vaginal / C-Section**

Pregnancies _____ Abortions _____ Miscarriages _____ Multiple Pregnancies _____ Living _____

Personal History of Cancer? Yes No If Yes, Where/When: _____

Medications

Allergies: _____ Reaction: _____

Pharmacy: _____ Mail Order Pharmacy: _____

(Please attach list for additional medications)

Medication	Strength	Dosage	Frequency
Example: Cipro	*250 mg*	*1 Tablet*	*2 x per day*

Lakeview Women's Health

Date: _____

To: _____

Address: _____

FAX: _____

REQUEST FOR RELEASE OF MEDICAL RECORDS

I hereby request my medical records be released to:

Heather Anderson, DNP, ARNP, CNM

Cathy Hoover, WHNP

365 S. Lake Havasu Ave.

Lake Havasu City, AZ 86403

Phone: (928) 733-6293

FAX: (928) 733-5145

Patient Name: _____

Signature: _____

Date of Birth: _____ Phone Number: _____

Address: _____

Dates/Records Requested: _____

Chart Notes, Lab Results, Radiology Reports, etc.

Acknowledgment of HIPAA:

I have been notified that there is a copy of the HIPAA Privacy Rule available for my review in the waiting room detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice and I request the following restriction(s) concerning the use of my personal and medical information.

Please list names of family or persons whom you are consenting Lakeview Women's Health to speak with regarding your personal medical information or to whom you consent for us to release copies of your medical records:

_____

_____

_____

_____

Signed:_____ Date:_____

Office Policy Regarding Orders and Results:

Results for any orders given at your appointment will be reviewed by the provider once they are received. All results will be called to patients on Friday's unless provider requests a sooner follow up or marks urgent.

If you have not received a call regarding your results within 2 weeks, it is the patient's responsibility to call the office to follow up.

Signed: _____ Date: _____

In Case of Emergency:

Name:_____Relationship:_____

Phone:_____Address:_____

Cancellation Policy:

We request that you please give our office a 24 hour notice in the event that you need to cancel or reschedule your appointment. This is will make the appointment time available for someone else.

If you miss an appointment and do not contact us with at least 24 hour prior notice, we will consider this to be a missed appointment and a $25.00 fee will be assessed to you.

As a courtesy, when time allows, we make reminder calls for appointments. If you do or do not receive a call or message, the cancellation policy will still remain in effect.

Signed:_____ Date:_____

Prescription Refills:

Please allow 72 hours for prescription refills. Please contact your pharmacy prior to running out of your prescriptions.

By signing below, I acknowledge I have read the Prescription Policy.

Signed:_____ Date:_____

Office Policy on Payment: Payment is due in full the day services are provided unless prior financial arrangements have been made. A late fee of $25.00 per month will be charged on outstanding accounts. I request the payment of authorized benefits payable by federal or state health care program commercial payer be made, on my behalf, to Lakeview Women's Health. I authorize release of any information from my clinic visit today to the billing company, health care financing administration and any other insurer needed to process my health claim. I may revoke this authorization at anytime, in which I am completely responsible for the charges accrued at the time of my clinic visit. I understand that I am financially responsible for the payment of any services provided. If payment is made with non-sufficient funds (NSF) a $25.00 fee will be added above and beyond the original charge. If your balance is unpaid, you will be sent to collections and a charge of 40% above the balance will be added to the original charge.

Insurance Policy: As a courtesy to you, we will be happy to submit charges to most insurance carriers, if you have provided us with policy numbers, address, place of employment and any other pertinent information. You are responsible for all deductibles and charges not covered by insurance. Please understand that as a third party, we cannot become involved in prolonged insurance negotiations, this is your responsibility.

I authorize the release of any medical information necessary to process any claim. This authorization may be revoked by me, at any time in writing.

Consent for Treatment: I voluntarily consent to receive medical and health care services provided by Heather Anderson, DNP, CNM and Cathy Hoover, WHNP. I understand that such services may include examinations and treatment. I understand that consent will be valid and remain in effect as long as I remain a patient of Heather Anderson, DNP, CNM and or Cathy Hoover, WHNP.

I have read the above and accept financial responsibility in full for this account.

Signed:_____ Date:_____

Consent for Email & Text Message Reminder Notifications

I authorize Lakeview Women's Health to send me reminder notifications via email and text message for any future scheduled appointments.

Date: _____

Patient Name: _____

Cell Phone#: _____

Email Address: _____

*****Please make sure you confirm your appointments when reminders are received as the office will no longer be making courtesy telephone call reminders for upcoming appointments*****

Patient Signature: _____