CAPITAL WOMEN'S CARE, LLC.

Please update the information below, sign the form, and return the form to the front desk. Thank you.

Patient Information

Today's Date:	Patient Medical Record Number	Referring Physician	Appointment Info

Name	Marital Status	Gender	Date of Birth	Social Security #

Address	Apartment #	City State Zip

Home	Cellular	Ext

Guarantor/Financially Responsible Party

Guarantor Name	Date of Birth	Social Security Number	Home Phone

Address	City State Zip	Day Phone

Employer	Employer Address	Occupation

Primary Insurance Information

Have you applied or intend to apply for Medical Assistance? (Circle your answer) Yes No Not Sure

Insurance Company	ID	Group

Address	City State Zip	Phone

Policy Holder Name	Policy Holder Date of Birth	Policy Holder Social Security

Policy Holder Employer	Patient Relation to Policy Holder	Insurance Effective Date

Secondary Insurance Information

Please note, insurance companies require you to notify them of other insurance. They may not pay the claim for this visit if the information is not in their system.

Insurance Company	ID	Group

Address	City State Zip	Phone

Policy Holder Name	Policy Holder Date of Birth	Policy Holder Social Security

Policy Holder Employer	Patient Relation to Policy Holder	Insurance Effective Date

Personal Representative Authorized To Access Protected Health Information

Name	Phone	Relationship to Patient

1. Financial Responsibility:

I certify that the information I have provided regarding my insurance coverage is correct and I authroize Capital Women's Care to verify insurance coverage and benefits allowed in accordence with my insurance plan's coverage.

I authorize that the payements be made directly to Capital Women's Care for all medical insurance benefits which are payable under the terms of my insurance policy for services provided. I agree to pay any copayment, coinsurance, or deductible as required by my insurance for the terms and regulations of my insurance plan.

Capital Women's Care may impose a no-show fee of $35.00 for appointments not cancelled 24-hours in advance. Capital Women's Care may impose reasonable interest, late charges, direct collection costs (25%) and or reasonable attorney's fees should my account become delinquent. There will be a $40.00 fee assessed for all returned checks.

2. Payment in full at time of service:

I understand that if Capital Women's Care does not participate with my insurance or I do not have insurance, payment is due in full at the time of service.

3. Release of Medical Information for Billing:

I hereby authorize Capital Women's Care to submit a claim and a copy of medical records related to such services, to my insurance company, health and welfare fund, Medical or Medicaid for medical services provided to me or my dependent. I also authorize Capital Women's Care to provide a copy of this release and a copy of medical records related to such services if requested by the payor. Further, I authorize Capital Women's Care to release medical information to my consulting or primary physicaian to assist with continutity of care. This release will expire one year from the date my signature below, unless I cancel this release in writing prior to that date.

4. Receipt of Privacy Notice:

I have been given the opportunity to review the Capital Women's Care Notice of Privacy Practices which provides a detailed description of how my Protected Health Information (PHI) is used and disclosed.

5. Non Covered Services:

I agree to pay for medical services provided to me or my dependant which are not covered by the benefits in my Insurance plan.

I AGREE TO THE ABOVE STATED CONSENT

Signature of Patient or Legal Guardian: Date:

CAPITAL WOMEN'S CARE, LLC.

Patient Information			
Name	Patient Medical Record Number	Today's Date:	Appointment Info

How did you learn about our Practice? (Circle all that apply)

Patient Referral ◯ Other Referral ◯ Website/Internet ◯ Ad//Radio/TV ◯ Other _____

Patient Race and Ethnicity (Please circle your response)

Ethnicity: Hispanic/Latino or Not Hispanic/Latino Current System Selection:

Race: Asian, Black or African American, White, American Indian or Alaska Native, Native Hawaiian or Other Pacific Islander

Current System Selection:

Patient Allergies (Please include your reaction to each Allergy)	
Allergen	Reaction

Patient Medications (Please include dosage for each medication)	
Medication	Dosage

Patient Preferred Pharmacy	
Pharmacy Name	Pharmacy Phone
Street Address	City State Zip

Patient Communication

Capital Women's Care physicians are dedicated to helping our patient's live healthy lifestyles. Your physician would like the opportunity to communicate with you via patient portal, email, and telephone about preventive health services such as well woman exams or other health promotion information. Also, there may be other messages we would like to send our patients, such as the announcement of new physicians or contract changes with insurance companies.

Patient Portal: The portal is the preferred communication method for all adults 18 years or older. This method requires an active email address and enrollment in the portal.

Email: Capital Women's Care makes this comitment to our patients about the collection of email information.

1. They will be for Capital Women's Care use only They will not be sold to any other entity.
2. The patient's privacy will be protected. The email address will not be used to communicate any personal health infomation or in any manner inconsistent with the Health Insurance Portability and Accountability Act (HIPAA)
3. Emails to our patients will be one way communications and, therefore, will not allow for conversations between the patient and physician/staff.

Telephone: As a service to our clients, we provide a courtesy appointment reminder and possibly other important calls that may be placed using a pre-recorded message. By providing your cell phone number, you consent to receiving such calls at this number.

All health related questions should continue to be addressed to the appropriate Capital Women's Care staff. Additional comments and questions on our privacy policy as it relates to electronic communications, should be directed to the Capital Women's Care Compliance Officer at privacy@cwcare.net or 301-340-8339, ext 201

Patient Name: _____ Email Address: _____

Patient Signature: _____ Date: _____

CAPITAL
WOMEN'S
CARE

Thank you for scheduling your well woman exam today. A "well woman exam" is considered a preventative or wellness visit. This visit will address preventative health only and is not meant to diagnose or treat problems.

If your provider addresses and/or treats other health issues at this visit that are new or chronic in nature instead of scheduling you for a follow up or sick visit, your health insurance company may assess an additional patient liability for those services. Although most insurance plans include benefits for one preventative health visit, some do not. If you have any doubts, please check with your insurance plan.

If you need further explanation about incurring additional fees for services provided during your visit today, please discuss your concerns with your provider.

I acknowledge that I have read this notice prior to being seen and I understand that depending on the issues addressed or treated during today's visit, additional charges may apply.

Patient Signature: _____ Date: _____

CAPITAL
WOMEN'S
CARE

Informed Consent For Ultrasound

An ultrasound examination is a painless procedure in which high-frequency sound waves are used to visualize the pelvis and fetus. Using ultrasound, information is obtained about the pelvic anatomy, fetal size and growth, fetal heart rate, placental position, amniotic fluid volume, multiple pregnancies, and major birth defects.

While a normal ultrasound is reassuring, it cannot exclude all abnormalities. Despite a normal ultrasound, some babies may be born with abnormalities not identified by the study. Similarly, a gynecological ultrasound may not be able to detect all abnormalities, such as scar tissue and endometriosis. Presently, ultrasound is not known to cause any harm to women or a fetus. Extensive evaluation for safety of ultrasound has confirmed this.

Should you have any questions concerning ultrasonography, do not hesitate to discuss them with your doctor or ultrasound technologist before undergoing the procedure.

You are requested to sign this document prior to the performance of your ultrasound examination, and thereby acknowledge that you have read and understood the information contained herein and have given an informed consent to this procedure. Your signature also acknowledges that you may not know the gender of the fetus after this exam, and understand that not all abnormalities may be discovered.

Do you have a allergy to latex rubber? Yes____ No____
If yes, please inform the technologist.

Patient Signature_____Date_____

CAPITAL WOMEN'S CARE

Working Together for Women's Health

Hereditary Cancer Questionnaire

Name: _____ Date of Birth: _____ Provider seeing today: _____

Instructions: please circle YES if you and/or any relatives have or have had the cancers listed below. Only consider first or second degree relatives (only first degree for pancreatic cancer).

Mother/Father/Sister/Brother/Your Children = First degree relatives
Uncle/Aunt/Grandparents/Nephew/Niece = Second degree relatives

CIRCLE YES OR NO			Specify Relative	Specify Cancer	Age at Diagnosis (Approximately)
NO	YES	Breast cancer in yourself			
NO	YES	Breast cancer diagnosed before the age of 50			
NO	YES	Three of more breast cancers ***on the same side of the family***			
NO	YES	Ashkenazi Jewish descent with at least one relative with breast cancer			
NO	YES	Ovarian Cancer			
NO	YES	Pancreatic Cancer in a ***first degree relative***			
NO	YES	Colon, rectal or uterine cancer diagnosed before the age of 50			
NO	YES	Three or more family members ***on the same side of the family*** with the following cancers: colon, rectal, uterine, ovarian, stomach, small intestine, kidney, or brain			

FOR OFFICE USE ONLY

- ☐ Patient is NOT appropriate for testing
- ☐ Patient is appropriate for testing
- ☐ Patient offered genetic testing: ACCEPTED or DECLINED

HCP Signature: _____ Date: _____