Richard Lorenzo, D.O.

Kortney Jones, ARNP

Complete Healthcare

Date: _____

Name_____ **DOB** _____ **Age** _____ **Height**_____

Who referred you to us? _____(Doctor) (Friend) (Internet) (Other)

Primary Care Physician: _____

Reason for Visit: □ Annual Exam □Other (specify) _____

□ Pregnant Due date: _____ Weight prior to pregnancy _____

List all of the medications (including supplements) that you take and dosage: _____

_____

Allergies: _____

What Pharmacy do you use? Name _____ Street _____ City _____

First day of your Last Menstrual Cycle: _____**How long does your period last?** _____ days

Description of Bleeding □ Normal □ Abnormal (describe)_____

Periods are: □ Regular □ Heavy □ Irregular & unpredictable □ Irregular & predictable

Menstrual Cycle is every □ <21 days □ 24-26 days □ 27-28 days □ 29-31 days □ 32-34 days □ >34 days

Do you feel your periods impact the quality of your life? □ Yes □ No

Contraception methods used in past: _____

Contraception currently being used: _____

How long have you been using current birth control: □ 2 years or less □ 3-5 years □ 6-10 years □ over 10 years

When are you planning to have another child? □ within 1 year □ within 5 years □ within 10 years □ I am done

Date of last Pap: _____ **Abnormal pap history?** □ Yes □ No

Date of last mammogram: _____ □ Normal □ Abnormal (specify) _____

Check any conditions YOU have:

□ Sinus Problems
□ Hypertension
□ Irritable Bowel Syndrome
□ Skin Condition
□ Diabetes
□ Headaches/migraines
□ Asthma
□ Gastric Reflux
□ Polycystic Ovaries
□ Chronic Bladder Infections
□ Seizure Disorder
□ Hypo/Hyper Thyroid
□ Heart Conditions
□ Respiratory Conditions
□ Gastroenterology Conditions
□Uterine Fibroids
□ Urinary Conditions
□ Neurological Condition
□ Anemia
□ Embolism
□ Chronic Yeast Infections
□ Muscle/Bone Conditions
□ Depression
□ Genetic Condition
□ Sexually Transmitted Disease – **Specify** _____

Other medical problems: _____

_____

_____

_____

_____

Pregnancy History (include any miscarriages or abortions):

Birthdate	Gestational Weeks	Birth Weight	Sex (F/M)	Delivery Type	Anesthesia	Living Y/N	Complications

Surgical History:

Date	Type	Complications

Is there a <u>FAMILY HISTORY</u> of (please include relationship and specify <u>Maternal or Paternal</u>):

□ Polycystic Ovarian Disease _____
□ Ovarian Cancer_____
□ Cervical Cancer _____
□ Uterine Cancer _____
□ Endometriosis _____
□ Early Menopause _____
□ Breast Cancer _____
□ Hypertension _____
□ Heart Disease _____
□ High Cholesterol _____
□ Birth Defects _____
□ Rheumatoid Arthritis _____
□ Hip Fracture _____
□ Osteoarthritis _____
□ Osteoporosis _____
□ Venous Thrombosis _____
□ Stroke _____
□ Diabetes _____
□ Bleeding Tendencies_____

Do you <u>currently</u> smoke or use any tobacco products? □ Yes □ No **Have you <u>previously</u>?** □ Yes □ No

How many cigarettes/packs per day? _____ **How long have you smoked?** _____

When did you quit smoking? _____ **Vaping?** □ Yes □ No _____**Mg?**

Illicit Drug Use? _____**Current?** □ Yes □ No **If Yes, History**: _____

Recreational Drug Use? _____ **Current?** □ Yes □ No **If Yes, History**:_____

Do you drink alcoholic beverages? □ Yes □ No

How many per day/week/month? _____
□ Wine □ Beer □ Hard Liquor

URINARY HEALTH

1. Do you ever leak urine when you cough, laugh or sneeze? □ Yes □ No
2. Do you ever feel as though you have to urinate urgently? □ Yes □ No
3. Do you feel like you have to urinate too frequently? □ Yes □ No
4. Do you ever experience painful urination? □ Yes □ No

Are there any concerns/issues that you would like to discuss today? _____
_____
_____

PERSONAL AND FAMILY GENETIC HISTORY

Date: _____

Name _____ **DOB** _____ **Age** _____

Do you, your partner or any family members have a history of:

- □ Thalassemia
- □ Spina bifida
- □ Tay-Sachs
- □ Anencephaly
- □ Huntington's Chorea
- □ Familial Dysautonomia
- □ Maternal metabolic disorder
- □ Hemophilia or other blood disorders
- □ Neural Tube Defect
- □ Down Syndrome
- □ Congenital Heart Defect
- □ Cystic Fibrosis
- □ Sickle Cell Disease or Trait
- □ Canavan Disease
- □ Intellectual Impairment or Autism
- □ Muscular Dystrophy
- □ Recurrent pregnancy loss or stillbirth
- □ 35 years or older as of EDC?

Do you or your partner have a history of genetic abnormalities or defects **not** listed above?
If yes, please explain:

_____
_____
_____
_____

***If you have questions regarding the disorders listed above, please ask the doctor at the time of your appointment. ***

PERSONAL AND FAMILY INFECTION HISTORY

- J Do you live with someone with TB or exposed to TB? YES NO
- J Do you or your partner have a history of genital herpes? YES NO
- J Have you had a rash or viral illness since your last menstrual period? YES NO
- J Have you or your partner been exposed to hepatitis B, C? YES NO
- J Do you or your partner have a history of STD, Gonorrhea, Chlamydia, HPV, HIV, Syphilis? YES NO

(This Page intentionally left blank)

Richard Lorenzo, D.O.

Kortney Jones, ARNP

Complete Healthcare

Patient Demographics

Name: _____

Date of Birth: _____ **Social Security Number:** _____

Mailing Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Home Number: _____ □ **Preferred** **Cell Phone Number:** _____ □ **Preferred**

Occupation: _____ **Employer:** _____ **Work Number:** _____

Would you like to receive appointment reminders via text message to your cell phone? □ yes □ no

May we leave confidential information on your voicemail? □ **yes** □ **no**

Email address: _____

Spouse Name: _____ **Occupation:** _____ **Employer:** _____

Insurance Co: _____ **Subscriber Name:** _____

ID#:_____ **Group#:**_____ **Subscriber D.O.B:**_____

Relationship to Subscriber: _____

Emergency Contact Name: _____ **Phone:**_____

Emergency Contact Relationship to Patient: _____

Authorization to release medical information:

I authorize the release of my medical information to the person(s) below:

_____ _____

Name of Person (Please Print) **Relationship to Patient**

Initial **the information you would like us to release to the person(s) above:**

-) **All** medical information (labs, ultrasounds, diagnosis, treatment, etc.) _____
-) **All** appointment & billing information _____
-) Insurance & Billing information **only** _____
-) Appointment information **only** _____

_____ _____

Patient Signature **Date**

(This Page intentionally left blank)

Richard Lorenzo, D.O.

Kortney Jones, ARNP

Complete Healthcare

Patient Name:_____ **DOB:** _____

Office Policies

Patient Financial Policy
Thank you for choosing Complete Healthcare for Women as your health care provider. We are committed to building a successful physician-patient relationship with you and your family. Your clear understanding of our patients' financial responsibility is important to our professional relationship. Please understand that payment for services is a part of that relationship. Please ask to speak to billing if you have any questions about our fees, our policies, or your responsibilities. It is your responsibility to notify our office in a timely manner of any patient information changes (i.e. address, name, insurance information, etc.).

Missed Appointments
If you need to cancel an appointment, we ask for at least a 24-hour notice. This allows us to offer the appointment to another patient. If you fail to keep your appointment without letting us know in advance you will get one visit reschedule prior to being charged a $50 no-show fee. Subsequent no shows will be assessed the fee. This fee will NOT be paid by your insurance and is your responsibility.

Patient Signature: _____ **Date:**_____

Co-pays
The patient is expected to present an insurance card at each visit. All co-payments and past due balances are due at time of check-in unless previous arrangements have been made with a Financial Counselor. **We accept cash, check, credit/debit cards and Care Credit.**

Insurance Claims
Insurance is a contract between you and your insurance company. We will bill your primary insurance company. In order to properly bill your insurance company, we require that you disclose all insurance information including primary and secondary insurance, as well as any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance. If we are out of network for your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately.

Self-pay Accounts
Self-pay accounts are patients without insurance coverage or patients without a current insurance card on file with us. It is always the patient's responsibility to know if our office is participating with their plan. If there is a discrepancy with information provided to us by the patient, the patient will be considered self-pay until the correct information is provided. Self-pay patients will be required to make payment arrangements for their balance.

Ultrasounds
Obstetrics ultrasounds are not included in the global package. Gynecology ultrasounds are not considered preventative care. In both cases there may be an out-of-pocket expense for these services. It is your responsibility to understand what your insurance allows.

Office Policies (continued)

Returned Checks
The charge for a returned check is $25.00 payable by cash or money order. This will be applied to your account in addition to the insufficient funds amount. You may be placed on a cash only basis following any returned check.

Medical Record Copies
A $25.00 fee will be charged for copies of medical records due at the time of the request.

Paperwork Fee
A $25.00 fee will be applied for the completion of FMLA paperwork or other forms due at the time of the request.

Minors
The parent(s) or guardian(s) are responsible for full payment.

Outstanding Balance Policy
Payment in full is expected on receipt of your billing statement. The statement will reflect the amount you owe after your insurance, if any, has processed your claim. If no resolution can be made within thirty (30) calendar days, the account may be sent to the collection agency.

This financial policy helps the office provide quality care to our patients. If you have any questions or need clarification of any of the above policies, please contact our Patient Billing Department at (866) 908-8431.

I _____have reviewed the above Complete Healthcare for Women Office Policy.
Print Name

Patient Signature:_____ **Date:**_____

Patient Name:_____ **DOB:** _____

**** If you have any questions or concerns with any of these policies, please request to speak to our billing department before you leave your visit or call with any questions.**

Richard Lorenzo, D.O.

Kortney Jones, ARNP

Complete Healthcare

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

At Complete Healthcare for Women, we believe that individuals have a right to adequate notice of our policies, procedures and practices with respect to uses and disclosures of protected health information. Complete Healthcare for Women is required by law to maintain the privacy of your health information and to provide you with a notice of our legal duties and privacy practices. We are required to and will abide by the terms in the Notice of Privacy Practices in effect at the time it is provided to you. You have the right to request a paper copy of this Notice of Privacy Practices at the time it is provided to you. You have the right to request a paper copy of this Notice of Privacy Practices even if we have provided a copy to you electronically by e-mail.

Complete Healthcare for Women will not use or disclose your individually identifiable or protected health information other than to carry out health care treatment, payment, and/or operations for you, or as required by law. An example of treatment is a visit to our office for the purpose of diagnosis or care of a health issue wherein doctors, nurses, laboratory technicians, medical students and others will share the information about you in the course of your treatment. Payment includes sharing protected health information with an insurer or a third party that may be responsible for collecting payment for a health plan. Healthcare operations means sharing protected health information for the purpose of quality review.

Complete Healthcare for Women will use and disclose protected health information to business associates in the course of providing treatment, securing payment for such treatment, and/or to facilitate health care operations of our practice, to facilitate the requirements of our business associates' contracts and to comply with requests from other covered entities to carry out treatment, payment or health care operations.

Except for the purposes described above, Complete Healthcare for Women will only use or disclose protected health information with your expressed written authorization, and you may revoke the authorization at any time in writing. The revocation will apply only to future uses and disclosures. Any information Complete Healthcare for Women provides to a third party other than to our business associates or other health care providers with a treatment relationship to you will be de-identified or stripped of any and all personal data which could be used to identify a specific individual.

Complete Healthcare for Women may contact you to provide appointment reminders or to provide you with information about alternative treatments or other health-care services we provide. When you provide alternate communication requests to us, we will make every effort to accommodate your request.

You may request that certain uses and disclosures of your protected health information be restricted. To do so, you must provide the request in writing using the Request for Restriction on Use or Disclosure form available from our office. Complete Healthcare for Women will determine if the information constitutes required information to carry out treatment, payment or health care operations. If, in our sole opinion, your request does not involve information that is required by us to carry out treatment, payment or health care operations, we will accept your request for restriction and will notify you if your request will be honored within 30 days or as required by law. (Continued on next page)

With respect to your protected health information, you have the right to request and receive the following from Complete Healthcare for Women: Inspection and copying -- You may request that we amend or correct your health information that has been collected by

Notice of Privacy Practices (continued)

Complete Healthcare for Women for you to inspect or copy. Such requests will be honored within 30 days or as required by law, and you will be notified in writing of Complete Healthcare for Women, receipt of the request and the date upon which the information will be available to you.

You may request that we amend or correct your health information that has been collected by Complete Healthcare for Women. Upon agreement by your health care provider, requests to amend health information will be honored within 30 days or as required by law, and you will be notified in writing of Complete Healthcare for Women actions taken.

Accounting of the disclosures -- You may request that we supply you with a listing of the disclosures of your protected health information which have been made by Complete Healthcare for Women except those made for treatment, payment or health care operation, those required by the Final Privacy Rule or made pursuant to other honored within 30 days or as required by law, and you will be notified in writing of the date on which the accounting will be available to you. At a minimum, the accounting of disclosures will include the following information.

- Date of each disclosure

- Name and address of the organization of person who received the protected health information

- A brief description of the information disclosed.

If you believe that your privacy rights have been violated, you may send questions or complaints about this notice to:

Complete Healthcare for Women
Attention HIPAA Privacy Contact
1045 Jadwin Avenue
Richland WA 99352

Or:

The Secretary of the Department of Health and Human Services (HHS)
200 Independence Ave. SW
Washington DC 20201.

Complete Healthcare for Women and will not retaliate against you for filing a complaint with the Secretary of HHS.

Complete Healthcare for Women reserves the right to revise this Notice of Privacy at any time without prior notification.

This Notice of Privacy Practices is effective as of 6/17/20.

I acknowledge that I have read, received and understand the Notice of Privacy Practices.

Signed: _____ **Date**:_____