

Registration Form

Please provide us with your insurance card and valid ID

Patient Information			
Name (Last, First, Middle)		Previous Last Name	
Florida Address		City/State/Zip + 4	
Out-of-State Address		City/State/Zip + 4	
Date-of-Birth		Social Security Number	
Driver's License Number		Email Address	
Home Phone	Work Phone	Cell Phone	
Primary Insurance			
Primary Insurance		Relation to Subscriber (self, spouse, child)	
Subscriber's Name		Subscriber's Employer	
Subscriber's Date of Birth	Subscriber SS #	Subscriber's ID #	Group #
Secondary Insurance			
Secondary Insurance		Relation to Subscriber (self, spouse, child)	
Subscriber's Name		Subscriber's Employer	
Subscriber's Date of Birth	Subscriber SS #	Subscriber's ID #	Group #
Emergency Contact			
Name	Relationship	Phone	
Referral Information			
How did you hear about us? <input type="checkbox"/> Doctor Referral <input type="checkbox"/> Internet <input type="checkbox"/> Telephone Directory <input type="checkbox"/> Patient <input type="checkbox"/> Television <input type="checkbox"/> Other _____			
Lab Results			
My preferred Pharmacy to use is: _____		Location: _____	Phone: _____
My preferred Lab to use is: _____		Location: _____	Phone: _____
How would you like to be contacted regarding your lab results? <input type="checkbox"/> Home Phone <input type="checkbox"/> Cell Phone <input type="checkbox"/> E-mail Is it okay to leave a detailed message with test results? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Appointments Confirmations			
We send annual and scheduled appointment reminders via phone, text and/or email which you must opt in to receive. It is extremely important to confirm the appointment upon receipt of the phone, email or text to ensure that we know you are planning to attend your appointment. How would you like to be contacted about your appointment? <input type="checkbox"/> Text <input type="checkbox"/> Phone <input type="checkbox"/> E-mail			



NAPLES WOMEN'S CENTER

A HealthLynked Company

HIPAA PRIVACY ACKNOWLEDGEMENT

I acknowledge that Naples Women's Center has given me an opportunity to review the "Notice of Privacy Practices" in compliance with current HIPAA regulations which are posted in the reception area. If I would like a copy of the HIPAA notice, I will ask for one.

Person signing this form must be 18 years or older. Proof of guardianship may be requested by staff.

Patient, Parent or Guardian Name (Print)

Patient, Parent or Guardian Signature

The following persons may be contacted in my place regarding appointments, billing, or medical care.

Personal Representative (Print)

Personal Representative Signature

Relationship

Date

ASSIGNMENT OF BENEFITS & RELEASE OF INFORMATION

I hereby request that payment of insurance benefits be made directly to Naples Women's Center on my behalf. I acknowledge and understand that I am financially responsible for all charges relating to the service(s) rendered to my dependent or myself. If, for any reason, my insurance carrier does not pay any portion of my bill, I agree to pay my portion promptly.

I also authorize Naples Women's Center to release any information acquired in the course of my examination or treatment to the insurance company or any other party involved in reimbursement for the claim.

Person signing this form must be 18 years or older. Proof of guardianship may be requested by staff.

Patient, Parent or Guardian Signature

Date

FOR MEDICARE PATIENTS ONLY

LIFETIME ASSIGNMENT OF MEDICARE BENEFITS

I request that payment of authorized Medicare/Medigap benefits be made to me or on my behalf to Naples Women's Center for any services furnished to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration (HCFA), its agents, and my Medigap insurer, any information needed to determine these benefits or the benefits payable for related services.

This assignment shall serve as a lifetime assignment, unless otherwise requested by me.

Signature of Patient or Personal Representative

Date

FINANCIAL AGREEMENT

Thank you for choosing Naples Women's Center. We believe that good medical care starts with good communication. We have created this policy to help our patients understand their responsibilities with respect to our fees.

Patient Information and Insurance

At each visit, you will be asked to verify your personal information, present a copy of your insurance card(s) and a picture ID, pay any outstanding balance and co-payment or charges due for that day's visit. In order for us to verify your insurance, we will ask you to update your insurance/demographic information annually, or more frequently if there has been a change in your coverage. Failure to notify us of a change in your coverage could lead to a denial of claims and patient responsibility of denied charges.

Co-Payments and Deductibles

Payment of co-pays are due at the time of service. We are required to collect co-pays per your contract with your insurance company. We accept cash, check and credit card.

Medical insurance may not cover the full cost of medical care. Certain costs, such as deductibles, co-payments and co-insurance, will be passed along to you by your insurance carrier and outlined in an Explanation of Benefits (EOB) that will be mailed by your carrier to you and this office. You are responsible for all amounts your carrier determines to be "Patient Responsibility".

Preventive vs. Medical Coverage

If you are here for a routine preventive exam/ annual well visit, this visit will be submitted as such to your insurance company. If during the course of your preventive visit the doctor addresses with you a problem (i.e., hypertension, pain, etc....) you may also receive a separate medical visit. Some insurance companies require separate copays, deductibles, or coinsurance for these different visits.

Surgical Services and Office Procedures

Surgery and obstetric deductibles may be pre-collected prior to procedure and delivery. The surgical fee includes the procedure performed by your physician and post-operative care for the procedure. Your financial portion is due in full before the surgery. The billing staff will contact you directly and speak with you regarding your scheduling and financial information.

Laboratory & Pathology Services

If your visit includes lab tests, biopsies, pap smears, cultures, etc. you will receive a separate bill from the lab.

Missed Appointments & Returned Check Fees

When an appointment is scheduled, that time is reserved for you and when it is missed or cancelled on short notice, that time cannot be used to see another patient. We require a 24-hour notification if you are unable to keep your appointment. There will be a twenty-five-dollar (\$25) charge for any missed appointments. There is also a thirty-five-dollar (\$35) fee for any returned check.

Overpayments and/or Refunds

If your Insurance company pays more than what is estimated, you will receive a refund check from our practice if your credit amount is over \$200. Please note that refunds will not be issued until after all your claims submitted for your services have been paid. Credit amounts under \$200 will remain on your account for future services at our practice unless requested by the patient. Medicare and Medicaid patients will receive any overpayment and /or refund regardless of the amount. Refunds can take up to 12 weeks to process.



Collections

Payment is due upon receipt of a statement. Once a patient account is over 90 days old, with no payment activity or attempts to contact the Billing Department to make payment arrangements, the account will be turned over to a Collection Agency. If you are having a financial problem, the most important thing you can do is contact our Billing Department to make payment arrangements. We provide reasonable payment plans designed to collect balances within a year.

We will do our best to help you with your insurance questions. Our Billing Department is available from 8:30AM to 5:00PM Monday through Friday at (239) 513-1992. You can also visit our Web site at www.napleswomenscenter.com and select **Online Portal** to make a payment.

Person signing this form must be 18 years or older. Proof of guardianship may be requested by staff.

Signature of Patient, Parent or Guardian

Date

NAPLES WOMEN'S CENTER: NEW PATIENT MEDICAL HISTORY FORM

Name: _____ Date of Birth: _____ Age: _____ Today's Date: _____

How did you hear about our office? Please circle: Friend/Family Online Primary Doctor Other _____

Reason for your visit today: Well Woman Exam or Problem visit: _____

WOULD YOU ACCEPT A BLOOD TRANSFUSION IN A LIFE OR DEATH SITUATION? (required): ☐ Yes ☐ No

Medical History: Have you had any of the following?

<input type="checkbox"/> Anemia	<input type="checkbox"/> Cancer _____	<input type="checkbox"/> Heart Disease/ Attack	<input type="checkbox"/> Pelvic Infections
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Chickenpox	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Reflux/Heartburn/Ulcer
<input type="checkbox"/> Asthma/COPD	<input type="checkbox"/> Depression/Anxiety	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Stroke
<input type="checkbox"/> Bladder Infections	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney Disease/Stones	<input type="checkbox"/> Thyroid Disorder
<input type="checkbox"/> Blood Clots in Lungs/Legs	<input type="checkbox"/> Epilepsy/ Seizures	<input type="checkbox"/> Liver Disease/Hepatitis _____	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> Gall Bladder Disease	<input type="checkbox"/> Migraines	<input type="checkbox"/> Other: _____

List ALL medications you are currently taking, including over-the-counter medications, vitamins, and herbal remedies:

List any allergies to medications: _____ ☐ No Known Allergies

Current Pharmacy: _____ **Location:** _____

Surgical History - List all surgeries with dates:

Obstetrical History

☐ Check here if you have **NEVER** been pregnant.

Number of pregnancies _____ Number of elective abortions _____ Number of ectopic pregnancies _____

Number of living children _____ Number of miscarriages _____ Number of stillbirths _____

Gyn History:

Age of first period _____ If in Menopause, what age/year _____

Date of last period _____

Cycle Length: every _____ days

lasting _____ days

Periods are:

☐ Regular

☐ Irregular

☐ Painful

Flow is:

☐ Light

☐ Moderate

☐ Heavy

☐ Very Heavy

Are you sexually active ☐ Yes ☐ No ☐ Never **New partners since last visit** ☐ Yes ☐ No

Sexual Preference: ☐ Heterosexual ☐ Homosexual ☐ Bisexual ☐ Other _____

Method of Birth Control

☐ Condoms ☐ Natural Family Planning ☐ Pills: _____ ☐ Vasectomy (Partner) ☐ Depo Provera
☐ IUD: Brand _____ Year inserted _____ ☐ Tubal/ Essure ☐ Vaginal Ring ☐ Cervical Cap
☐ Sponge ☐ Spermicide ☐ Withdrawal ☐ Other ☐ None

Have you ever had any of the following STDs?

☐ Chlamydia ☐ Hepatitis B ☐ Herpes ☐ HPV ☐ Trichomonas
☐ Gonorrhea ☐ Hepatitis C ☐ HIV ☐ Syphilis ☐ None

Name: _____ Date of Birth: _____

Date of last Pap Smear? _____ ☐ Normal ☐ Abnormal

If pap was abnormal, were any of the following performed: ☐ Colposcopy ☐ Cryosurgery ☐ LEEP/Laser/Conization

Date of last Mammogram? _____ ☐ Normal ☐ Abnormal ☐ Never had a Mammogram

Date of last Bone Density? _____ ☐ Normal ☐ Osteopenia ☐ Osteoporosis ☐ Never had a Bone Density

Date of last Colonoscopy? _____ ☐ Never had a Colonoscopy

Family History:

Father's side:

☐ Breast Cancer ☐ Depression ☐ Heart Disease ☐ Ovarian Cancer ☐ Uterine Cancer
☐ Colon Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Thyroid Disorder ☐ Blood Clots
☐ Other _____

Mother's side:

☐ Breast Cancer ☐ Depression ☐ Heart Disease ☐ Ovarian Cancer ☐ Uterine Cancer
☐ Colon Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Thyroid Disorder ☐ Blood Clots
☐ Other _____

Social History:

Exercise	<input type="checkbox"/> Yes <input type="checkbox"/> No	Type(s) and frequency _____
Alcohol use	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, _____ drink(s) per day/week/month
Tobacco use	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, _____ pack(s) per day for _____ year(s)
Caffeine	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, _____ caffeinated drinks (coffee, tea, soda) per day/week/month
Recreational Drug use	<input type="checkbox"/> Yes <input type="checkbox"/> No	Type(s) and frequency _____
Emotional Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, are you safe now <input type="checkbox"/> Yes <input type="checkbox"/> No Counseling <input type="checkbox"/> Yes <input type="checkbox"/> No
Physical Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, are you safe now <input type="checkbox"/> Yes <input type="checkbox"/> No Counseling <input type="checkbox"/> Yes <input type="checkbox"/> No
Sexual Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, are you safe now <input type="checkbox"/> Yes <input type="checkbox"/> No Counseling <input type="checkbox"/> Yes <input type="checkbox"/> No

Review of Systems - Do you have any of the following symptoms TODAY?

GENERAL:

<input type="checkbox"/> Yes <input type="checkbox"/> No	Generally healthy
<input type="checkbox"/> Yes <input type="checkbox"/> No	Recent weight gain/loss of 25 lbs.
<input type="checkbox"/> Yes <input type="checkbox"/> No	Fever
<input type="checkbox"/> Yes <input type="checkbox"/> No	Vision problems (excluding glasses)
<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus problems
<input type="checkbox"/> Yes <input type="checkbox"/> No	Hearing loss
<input type="checkbox"/> Yes <input type="checkbox"/> No	Chest Pain
<input type="checkbox"/> Yes <input type="checkbox"/> No	Varicose Veins
<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of breath
<input type="checkbox"/> Yes <input type="checkbox"/> No	Chronic Cough
<input type="checkbox"/> Yes <input type="checkbox"/> No	Diarrhea
<input type="checkbox"/> Yes <input type="checkbox"/> No	Constipation
<input type="checkbox"/> Yes <input type="checkbox"/> No	Blood in stools
<input type="checkbox"/> Yes <input type="checkbox"/> No	Heartburn/reflux

GYNECOLOGY:

<input type="checkbox"/> Yes <input type="checkbox"/> No	Abnormal Frequent urination
<input type="checkbox"/> Yes <input type="checkbox"/> No	Burning w/ urination
<input type="checkbox"/> Yes <input type="checkbox"/> No	Incontinence
<input type="checkbox"/> Yes <input type="checkbox"/> No	Abnormal Urinary Urgency
<input type="checkbox"/> Yes <input type="checkbox"/> No	Bladder infection
<input type="checkbox"/> Yes <input type="checkbox"/> No	Abdominal pain
<input type="checkbox"/> Yes <input type="checkbox"/> No	Abnormal vaginal discharge
<input type="checkbox"/> Yes <input type="checkbox"/> No	Irregular vaginal bleeding
<input type="checkbox"/> Yes <input type="checkbox"/> No	Pelvic pain
<input type="checkbox"/> Yes <input type="checkbox"/> No	Painful intercourse
<input type="checkbox"/> Yes <input type="checkbox"/> No	Breast lumps
<input type="checkbox"/> Yes <input type="checkbox"/> No	Breast pain
<input type="checkbox"/> Yes <input type="checkbox"/> No	Back pain
<input type="checkbox"/> Yes <input type="checkbox"/> No	Depression/anxiety

(PLEASE NOTE: Extra charges may/will occur if both a Well Woman exam and Problem visit are discussed on the same day)

Patient Signature

Date



Patient Payment Policy

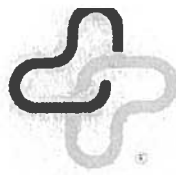
Naples Women's Center does not participate with all insurance companies, and each patient is responsible to know their insurance benefits as policies vary from person to person even with in the same insurer.

Co pays and deductibles may be due and are required to be collected at the time of your visit.

If we do not participate with your insurance, you will be asked to pay for your services at the time of visit. We will provide a receipt for your visit that you can submit to your insurance for reimbursement or if possible, we may submit to your insurance for reimbursement on your behalf.

Patient or Responsible Party Signature

Date



NAPLES WOMEN'S CENTER

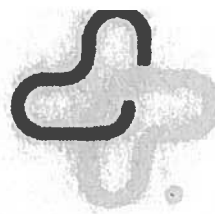
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CONSENT FOR MEDICAL TREATMENT AND SERVICES

I, voluntarily, consent to the physical exam, treatment and/or procedures under specific instructions of the healthcare provider at NAPLES WOMEN'S CENTER. Our number one priority is our patients' health. Our physician's assign codes that we will submit to your insurance based on the service they provided at the time of your visit.

Print Name: _____ **Signature:** _____

Date: _____



NAPLES WOMEN'S CENTER

Healthcare Company

CONSENT FOR SERVICES

1. If you are here for a scheduled **Gynecology** appointment with one of our providers, please note that most insurance companies have an allowable number of annuals every 12-24 months and it is your responsibility to know if you are having your exam within your insurance company's guidelines. If you are not within the allowable time frame for your exam, your insurance will deny the claim we send, and it will be **your responsibility to pay your bill in full**.
2. If you are here for a Schedule visit with a **Gynecology** provider and you discuss **ANYTHING** that addresses a problem issue (i.e.: burning, itching, discharge, foreign body, etc.) along with your annual exam, that warrants being billed for BOTH your annual and your problem visit.
3. Effective December 5th, 2022, ALL patients will be required to pay an **Annual Patient Administration Fee** of \$100. This fee is not billable to insurance and non-reimbursable. The fee includes consulting patients over the phone, faxing documents to employers and other healthcare providers for continuity of care, calling in prescription refills, and completing any necessary forms you, the patient, may need.

Please note: Problem visits and Annual visits are NOT to be done at the same time and the services cannot be combined. If you are experiencing a problem, that should be addressed in one visit. Your annual will then be a separate visit. The reason we do not combine the visit types is because you, the patient, will be responsible for the bill in full when your insurance only covers one of the visit types. In the event a provider finds a problem during your annual exam that cannot wait to be addressed at a later date, your insurance may require you to pay a co-pay and/or deductible/coinsurance for the visit because of the annual and problem visit charge on the same day.

I have read and understand all the information above and agree that regardless of my insurance status, I am responsible for the balance on my account. In the event my insurance company is billed, I authorize all payments of medical benefits to be paid directly to Naples Women's Center.

Print Name: _____

Signature: _____

Date: _____