WOMEN'S HEALTH CARE OF MORGANTOWN

304-599-6353 / 304-598-3608 FAX
www.whcofmorgantown.com

Welcome To Our Practice

We appreciate your selection of our office to serve your obstetric and gynecologic needs. We are committed to providing compassionate, high quality women's health care. We strive to develop caring relationships with our patients, involving you in your treatment plan. We have an excellent, well-trained, caring staff and they are always available to answer any of your questions.

Office Hours

Monday - 7:30 to 5:30
Tuesday - 7:30 to 5:30
Wednesday - 7:30 to 5:30
Thursday - 7:30 to 5:30
Friday - 8:00 to 12:00

Financial Policy

1. **If you do not have insurance coverage, payment is expected in full at the time of service unless other financial arrangements are made in advance with our Billing Department.**
2. **If you have insurance coverage and we are contracted with them, your co-pay is due at the time of service. We are contractually bound with the insurance co. to collect co-pays at the time of service. Co-pays will be collected at the time of check-in.**
3. **We accept cash, check, VISA, MasterCard and Discover.**
4. **If you are un-insured, we do offer some discount plans. If your balance is over $1000, the discount is 35%. If your balance is under $1000, the discount is 15%. We offer a 35% discount on all routine, wellness exams, if paid in full at time of service.**
5. **We do offer payment plans. If you need to set up a payment plan, please contact our Billing Department.**
6. **We do not charge any interest or finance charges.**
7. **We do bill most insurance companies for our services; however you are ultimately responsible for the balance on your account. After your insurance has responded to our claim, you will be mailed a statement for any balance due.**
8. **Please maintain your account with our office in good standing. Should your account become delinquent, your account may be turned over to our collection agency or attorney.**
9. **We charge a $35.00 fee for all returned checks.**

Broken Appointments

A 24-hour notice is preferred for appointment cancellations and reschedules, when possible. If you repeatedly "NO SHOW" for your appointments, you may be subject to possible termination from our practice. Our fee for missed appointments is $20.00.

Prescription Requests

Prescription refills will only be authorized during normal office hours so that we may have access to your medical record. Please allow 24 hours for this process to be completed. If you have not seen your provider within the previously recommended time frame for follow-up, you will need to schedule an appointment before refills can be authorized.

Emergency Services

Due to the nature of our practice, often times it is necessary for our doctors or midwives to be called away to the hospital for emergencies or deliveries. We appreciate your understanding if this should happen to you. We do our best to notify you in advance if an emergency arises, however, we don't always have much notice. If you are in an emergency situation and need to contact one of our providers after hours, please call our answering service at 304-292-5390. In the event of a severe situation, call 911 or go directly to Monongalia General Hospital.

Again, we thank you for choosing Women's Health Care of Morgantown. If you have any questions about any area of our practice, please feel free to contact our office manager, Karen Lavery, at 304-599-6353.

Our success is measured only by your satisfaction with the health care you receive. We welcome your comments as to how we may better care for your medical needs. Please grab one of our patient satisfaction surveys on your way out and ask for a self-addressed stamped envelope. Thank you for taking the time to complete one!

Louise E. Van Riper, M.D.
William Hamilton, M.D.
Craig Herring, M.D.
Murshid Latif, M.D.
Shane Prettyman, M.D.

Jan Thomas, C.N.M.
Gail Rock, C.N.M.
Lisa Stout, C.N.M.
Rhonda Conley, C.N.M.
Bjarni Thomas, C.N.M.

DATE ______________________

PATIENT REGISTRATION

FOR INTERNAL USE ONLY
PATIENT NUMBER ______________________

PATIENT INFORMATION

WHAT WOULD YOU LIKE TO BE CALLED ______________________

SOCIAL SECURITY # ______________________

FIRST NAME ______________ MIDDLE ______________

LAST NAME ______________________

SEX __________ DATE OF BIRTH ____ / ____ / ____

MARITAL STATUS ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED

(CHECK ONE) ☐ EMPLOYED ☐ RETIRED ☐ FULL TIME STUDENT

EMPLOYER ______________________

HOME ADDRESS ______________________

____

CITY ______________ STATE ________ ZIP ________

EMAIL ______________________

PRIMARY PHONE (______) ______________________

SECONDARY PHONE (______) ______________________

OTHER PHONE (______) ______________________

HOW DID YOU HEAR OF US? ______________________

INSURANCE INFORMATION

PLEASE PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST

☐ Commercial ☐ Medicaid ☐ Medicare

INSURANCE COMPANY ______________________

INSURED / CARD HOLDER'S NAME ______________________ RELATIONSHIP ______________

CARD HOLDER'S D.O.B. ______________ SS # ______________ ADDRESS ______________

POLICY # ______________ GROUP # ______________ PHONE (______) ______________

SPOUSE / GUARANTOR / RESPONSIBLE PARTY

SOCIAL SECURITY # ______________________

RELATIONSHIP ______________________

FIRST NAME ______________ MIDDLE ______________

LAST NAME ______________________

ADDRESS ______________________

CITY ______________ STATE ________ ZIP ________

SEX __________ DATE OF BIRTH ______________

DAYTIME PHONE (______) ______________________

CELL PHONE (______) ______________________

EMPLOYER ______________________

SECONDARY INSURANCE INFORMATION

☐ Commercial ☐ Medicaid ☐ Medicare

INSURANCE COMPANY ______________________

INSURED / CARD HOLDER'S NAME ______________________ RELATIONSHIP ______________

CARD HOLDER'S D.O.B. ______________ SS # ______________ ADDRESS ______________

POLICY # ______________ GROUP # ______________ PHONE (______) ______________

EMERGENCY CONTACT

SOCIAL SECURITY # ______________________

FIRST NAME ______________________

LAST NAME ______________________

CELL PHONE # (______) ______________________

HOME PHONE (______) ______________________

WORK PHONE (______) ______________________

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services.

____
SIGNATURE (Patient or Parent if Minor) DATE

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the Physician to release any information acquired in the course of my treatment necessary to process insurance claims.

____
SIGNATURE DATE

FINANCIAL STATEMENT AND AUTHORIZATION

I understand that I am personally responsible for all charges whether or not payable by my insurance company. I understand that I am financially responsible if I have not followed all the rules set forth by my insurance company. I agree to pay all applicable co-payments before services are rendered.

I give permission to Women's Health Care of Morgantown to file claims to my insurance company and allow my medical records to be sent to my insurance company if needed. I authorize and request that insurance payments be made directly to Women's Health Care of Morgantown. I give permission to file a complaint with the insurance commissioner in the event that there is ever a dispute between Women's Health Care of Morgantown and my insurance company. I understand that I will be notified before a complaint would be filed with the insurance commissioner.

I have read and fully understand the above consent for financial responsibility, release of information and insurance authorization.

______________________________ ______________________________
Patient Name Date

______________________________ ______________________________
Signature Relationship to patient (if minor)

Women's Health Care of Morgantown

BRIEF HISTORY

In an effort to serve you better, we request that you provide us with the following information. We need this information to give you the best care and treatment possible. All information is held strictly confidential and is released only with your written consent.

PATIENT INFORMATION

DOCTOR NOTES *Please do not write in this area*

LAST NAME: FIRST: DOB: SEX:

ILLNESS/INJURY: Please check if you have ever had:

Yes	No		Yes	No	
		High blood pressure			Kidney stones
		Diabetes			Abdominal bleeding
		Peptic ulcers			Diverticulosis
		Heart attack			Thyroid problem
		Chest pain / tightness			Lung problems / asthma
		History of heart murmur			Shortness of breath
		Stroke			Accidents / broken bones (list)
		Cancer			
		Hepatitis			
		Yellow jaundice			
		Gallstones			

OPERATIONS: List names and dates of all operations you have had ■ None

Year	Name of Operation	Type of Anesthetic, if Known	Complications

Have you ever had a blood transfusion? ☐ Yes ☐ No Date: ____

Family Hx: ____

List all pregnancies: ____

Are you pregnant? ☐ Yes ☐ No Date: ____

DRUGS: Please list all drugs you take and their dosages. ■ None

Drug	Dosage	Drug	Dosage

ALLERGIES: Please list type and reaction. ■ None

Name of Drug	Reaction	Name of Drug	Reaction

Reviewed by: ____

Date: ____

Do you now use tobacco? ☐ Yes ☐ No Day # Yrs ____ / ____

Have you ever used tobacco? ☐ Yes ☐ No Yrs Quit ____

Do you drink alcohol? ☐ Yes ☐ No Day # Yrs ____ / ____

Recreational drugs? ☐ Yes ☐ No

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
AND
COMMUNICATIONS CONSENT

I acknowledge that I have received or have been offered a copy of the *Notice of Privacy Practices*

____________________________________	____/____/____	____/____/____
Patient or Personal Representative Signature	Patient's Date of Birth	Today's Date

(Please circle relationship: ***Self Parent Guardian Spouse***)

TELEPHONE COMMUNICATION

1. Primary Telephone #:	2. Secondary Telephone #:	3. Addition Phone #:
(_____) -_____ -_________	(____) -_____-_________	(____)-_____-_________
(Please circle one: cell home work spouse other)	(Please circle one: cell home work spouse other)	(Please circle one: cell home work spouse other)
___ May leave detailed message.	___ May leave detailed message.	___ May leave detailed message.
___ May only leave a call back number.	___ May only leave a call back number.	___ May only leave a call back number.

I give permission for Women's Health Care to discuss my medical information with the following:
(if you wish for us to speak to **NO ONE** please write "No on" on the first line)

Name: ______________________________ **Relationship:** ____________________
(**Please circle *all* that apply**: appointment information / test&lab results / billing information)

Name: ______________________________ **Relationship:** ____________________
(**Please circle *all* that apply**: appointment information / test&lab results / billing information)

Name: ______________________________ **Relationship:** ____________________
(**Please circle *all* that apply**: appointment information / test&lab results / billing information)

WRITTEN COMMUNICATION
(Please circle yes or no for each of the questions below)

Please expect to get billing statements, test results, and other medical information mailed to the address that is most current, provided by the patient, that is on file

Yes No Ok to fax to this number (_____) _____ - _________

Yes No Patient information or medical records may be faxed to other health care providers, hospitals, or insurance if necessary.

I agree this it is my responsibility to inform Women's Health Care of Morgantown, in writing, if I wish to change any of the above information for future disclosure.

____________________________	____________________________	____/____/____
Print name	Patient Signature	Today's Date

WOMEN'S HEALTH CARE OF MORGANTOWN

1249 Suncrest Towne Centre, Morgantown, WV 26505 Phone: (304) 599-6353 Fax: (304) 598-3608
28 Morgantown Street, Suite #2, Kingwood, WV 26537 Phone: (304) 441-2010 Fax: (304) 441-2042
www.whcofmorgantown.com

NOTICE OF INFORMATION PRACTICES

Protecting the privacy of your personal health information is important to us. This notice describes how information about you may be used and disclosed and how you can obtain access to this information. Please read carefully.

Disclosure of your protected health information (PHI) without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining your consent. You may request restrictions on disclosures.

Disclosures of PHI are limited to the minimum necessary for the purpose of the disclosure. This provision does not apply to the transfer of medical records for treatment.

You may inspect and receive copies of your records at any time. You are required to fill **out** a release to receive copies of your records. There may be a fee charged for photocopying, postage and preparation.

You may request changes to your records. Our practice has the right to accept or deny your request.

We maintain a history of PHI disclosures that is accessible to you.

We may contact you for appointment reminders, announcements, and test results. You will be given a communications consent to fill out with your contact information.

Our practice is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be prominently displayed in a clearly visible location in our practice.

You may file a complaint about privacy violations by contacting our office manager, Karen Lavery at 304-599-6353.

Revised: March 25, 2009