How Did You Hear About Us?

Thank you for choosing the physician practices of Carolinas Physicians Network. We would appreciate you taking the time to complete this form.

Please select one of the following:

Did you hear about us in one of the following ways:

Community Seminar/Event	Where/When: _____
Mail	_____
Newspaper Advertisement	Publication: _____
Patient Resource Center Brochure	_____
Radio Advertisement	Station: _____
Saw the Facility	_____
Social Services	_____
Television Advertisement	Station: _____
Internet Search/Web site	_____
Yellow Pages	_____
Other	_____

Whom may we thank for referring you to our practice?

Carolinas HealthCare System Employee	Name: _____
Employer	Name: _____
Friend	Name: _____
Insurance Provider	Name: _____
Physician Referral	Name: _____
Relative	Name: _____

Your Name: _____

Carolinas Physicians Network

Eastover-University Obstetrics & Gynecology

AUTHORIZATION, ASSIGNMENT OF BENEFIT, AND REFERRAL MEDICAL RELEASE:

I hereby authorize consent for medical examination and treatment, to include but not limited to, obtaining blood samples, x-rays, medication administration, and patient education by the healthcare providers of this facility. I understand that I have the right to be informed by my physician of the nature and purpose of any proposed procedure, alternative methods of treatment, and an explanation of the risks and benefits of both. This form is not a substitute for that explanation.

The consent of a parent or guardian is required for the treatment of minors. A minor is any person under 18 years of age. This practice requires that a minor be accompanied by a parent or guardian.

I hereby authorize the release of medical information including complete medical records, test results, and billing information to my insurance company, and to other medical professionals and medical care institutions that I may be referred to for treatment. I understand that this information will be used to review, investigate, or make payment of a claim, and to review records for quality improvement initiatives, audit compliance, utilization management, and complaint resolution.

I authorize payment directly to Carolinas Physicians Network for all medical or surgical benefits otherwise payable to me under terms of my insurance/workman's comp. I understand that I am financially responsible for all co-payments, co-insurance, deductibles, and non-covered services. I also understand I will be responsible for any charges incurred should my account be referred to an outside agency for collection. A photocopy of this authorization shall be considered as effective and valid as the original.

Patient Signature _____ Date *(valid for one calendar year)* _____

Annual Physical Review

Name: _____ Reason for Visit: _____

Address: _____ Phone: _____

Date of Visit: _____ DOB: _____ Age: _____ Occupation: _____

Primary Care Physician & Phone #: _____

***ALLERGIES: _____

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Domestic Partner

Menstrual History:

Last Menstrual Period: _____

Days of Flow: _____ Amount: *(heavy, normal, light)* _____ Length Between Periods: _____

Have you ever been pregnant? ☐ Yes ☐ No

How many times: _____

Full Term _____ # Pre Term _____ # Miscarriage / Abortion _____ # Living Children _____

Any pregnancy complications: _____

Do you use birth control?

☐ Pills ☐ Diaphragm ☐ Depo Provera ☐ Implanon/Norplant ☐ Abstinence ☐ None Needed

☐ IUD ☐ Vasectomy ☐ Tubal Ligation ☐ Condoms ☐ Rhythm Method

Do you use hormone replacement? ☐ Yes ☐ No Rx: _____

Medical History: *Check if you have had any of the following:*

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	Cancer	☐	☐	High Blood Pressure	☐	☐	Anemia	☐	☐	Depression
☐	☐	Abnormal Pap Smear	☐	☐	Heart Disease	☐	☐	Thyroid Problems	☐	☐	Alcoholism
☐	☐	Pelvic Infection	☐	☐	Mitral Valve Prolapse	☐	☐	Diabetes	☐	☐	Digestive Problems
☐	☐	Sexually Transmitted Disease	☐	☐	High Cholesterol	☐	☐	Tuberculosis	☐	☐	Drug Addiction
☐	☐	Phlebitis / Blood Clots in Legs	☐	☐	Migraine Headaches	☐	☐	Hepatitis	☐	☐	Infertility

Date of Last: Colonoscopy _____ Bone Density _____ HPV vaccine _____ (Gardasil) _____

	Yes	No	
Do you perform breast exams on yourself?	☐	☐	How often? _____
Have you had a mammogram of your breasts?	☐	☐	If so, when? _____
Have you ever had an abnormal mammogram?	☐	☐	If so, when? _____
Have you ever had an abnormal pap smear?	☐	☐	If yes, What kind of treatment? _____
Do you have a pap smear yearly?	☐	☐	
Do you take any other medications	☐	☐	Please List _____

Surgical History:

Have you had any female surgery? Yes ☐ No ☐ If so, what type? (check below):

☐ Breast ☐ Hysterectomy ☐ D&C ☐ Ectopic Pregnancy ☐ Fibroid Tumors

☐ Ovary ☐ Laparoscopy ☐ Cesarean Section ☐ Laser/LEEP/Cryo of Cervix ☐ Other

Reason for Surgery / Findings _____

Please list any other surgery: *(i.e., appendectomy, heart surgery)* _____

Reviewed by: _____

(Please complete back side of page)

Social History / Habits:

	Yes	No				
Have you ever smoked?	☐	☐	How Much? _____	☐ Quit	Years? _____	
Do you drink alcohol?	☐	☐	How Much? _____	How Often? _____		
Do you use street drugs?	☐	☐	What Kind? _____	How Often? _____		
Are you at risk for HIV infection?	☐	☐				
Are you or have you ever been threatened or physically, sexually or mentally abused?	☐	☐				
Do you exercise?	☐	☐	How Often? _____			

Family History: *(Siblings, Parents, Grandparents)*

Please check (✓) appropriate box if a family member currently has or previously had one of these illnesses. Check every listing.

Yes	No			Yes	No		
☐	☐	Breast Cancer	_____	☐	☐	Tuberculosis	_____
☐	☐	Ovarian Cancer	_____	☐	☐	Diabetes	_____
☐	☐	Other Cancer	_____	☐	☐	Bleeding Disorder	_____
☐	☐	Birth Defects	_____	☐	☐	Alcoholism	_____
☐	☐	High Blood Pressure	_____	☐	☐	Mental Retardation	_____
☐	☐	Heart Attack	_____	☐	☐	Osteoporosis/Osteopenia	_____
☐	☐	High Cholesterol	_____	☐	☐	Other	_____

REVIEW OF SYSTEMS - *Please check if you are having problems with any of the following:*

Genital / Urinary

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	Vaginal Warts	☐	☐	Heavy Vaginal Bleeding	☐	☐	Painful Intercourse	☐	☐	Urination at Night
☐	☐	Vaginal Dryness	☐	☐	Irregular Vaginal Bleeding	☐	☐	Urinary Urgency	☐	☐	Bladder Control / Leakage
			☐	☐	Painful Menstrual Periods	☐	☐	Pain / Burning with Urination	☐	☐	Urinary Tract Infections

Endocrine

☐	☐	Fatigue	☐	☐	Hair Loss	☐	☐	Absence of Menstrual Periods	☐	☐	Hot Flashes

Skin / Breast

☐	☐	Nipple Discharge	☐	☐	Sore That Does Not Heal	☐	☐	Changes in Mole	☐	☐	Rashes / Persistent Itching
☐	☐	Breast Lumps / Tenderness									

Neurological

☐	☐	Frequent Headaches	☐	☐	Poor Coordination	☐	☐	Muscle Weakness	☐	☐	Trouble Sleeping

Psychiatric

☐	☐	Depression	☐	☐	Anxiety	☐	☐	Memory Changes	☐	☐	Counseling or Treatment
☐	☐	Mood Swings									

ENT

☐	☐	Visual Problems	☐	☐	Allergies / Hayfever	☐	☐	Frequent Sore Throat	☐	☐	Mouth Ulcers
☐	☐	Hearing Loss	☐	☐	Hoarseness	☐	☐	Sinus Problems			

Digestive

☐	☐	Heart Burn	☐	☐	Rectal Bleeding	☐	☐	Diarrhea	☐	☐	Yellow Jaundice
☐	☐	Vomiting	☐	☐	Black Stools	☐	☐	Significant Weight Change (i.e., < or > 10-15 lbs. / yr.)			

Cardiac

☐	☐	Chest Pain	☐	☐	Irregular Heart Beat	☐	☐	Fainting / Dizziness

Respiratory

☐	☐	Shortness of Breath	☐	☐	Coughed Blood	☐	☐	Wheezing

Eastover-University Obstetrics & Gynecology

PERSONAL INFORMATION SHEET

Date_____

Full Name of Patient : _____
(First) (Middle) (Last)

Age : _____

Date of Birth : _____

Social Security Number : _____

Address : _____
(Street & Number)

_____
(City) (State) (Zip Code)

Home Phone Number : _____

Place of Employment : _____

Employer's Address : _____

Work Phone : _____

Guarantor : _____

Spouse or Parent's Name : _____
(Circle One)

Their Employer : _____

Their Employer's Address: _____

Their Work Phone : _____

Date of Birth : _____

Social Security Number : _____

Referred By : _____

Carolinas Physicians Network

Carolinas HealthCare System

PAYMENT POLICY & PATIENT STATEMENT OF RESPONSIBILITY

TO OUR VALUED PATIENTS:

THANK YOU for choosing Carolinas Physicians Network for your healthcare services. We strive to provide the highest quality of care yet keep your healthcare costs as low as possible. These policies reflect our efforts to reduce healthcare costs. We appreciate your full cooperation.

FOR YOUR CONVENIENCE we accept any debit or credit card with the MasterCard, Visa, Discover, or American Express logo, as well as your personal check or cash.

PAYMENT (such as co-pays, deductibles & co-insurance) is required at the time of service. We request that you do not ask to be billed. Patients repeatedly asking for exceptions will be directed to a supervisor or practice manager.

INSURANCE CARDS must be presented at each visit. You may feel this is unnecessary, but insurance plans are becoming more complicated, and cards, policy numbers, and renewal dates are constantly changing. In order for us to file your claims with the appropriate plan, we must have the most recent card presented. **If you arrive without your card**, you will be responsible for all charges until the billing office has received complete, current, and accurate insurance information. Most plans require we file your claim within 90 days from the date of service. If we have not received your information within that time, you will remain responsible for all charges incurred up to the date you provide us with your insurance information and we receive payment from the insurance plan. Any balance you owe should be paid within thirty days.

MEDICARE PLANS are more numerous and complicated. Carolinas HealthCare System and Carolinas Physicians Network participate with **Traditional Medicare (Part A & Part B)** only. We do not accept any Medicare Advantage managed care plans except for emergency situations. Please notify the front office immediately if you have recently changed Medicare plans. Medicare deductibles and co-insurance are expected at the time of service. As a participating provider with Medicare, we will file your claim to Medicare and if applicable, to your secondary insurance carrier.

MANAGED CARE PLANS have a network of participating providers. We participate with most major plans, but please contact your plan or check their website or call our office for confirmation before your visit. Applicable co pays, co-insurance and deductibles are expected at time of service. You will also be billed for any non-covered services for which you are liable after your insurance pays their share. If you have a managed care plan that we do not participate with, you will be expected to pay the bill in full at the time of service.

COMMERCIAL INSURANCES are those plans we do not participate in. You will be responsible for payment in full at the time of service. Since we are non-participants in the plan, we do not accept the Usual & Customary fee. As a courtesy, we will file your claim.

WORKER'S COMPENSATION may or may not be accepted by your provider. Please check with your provider before making an appointment. If your provider accepts Worker's Compensation, you will be seen upon approval and authorization by your employer with the proper documentation.

MEDICAID may or may not be accepted by your provider. Please check with your provider before making an appointment. If your provider does accept Medicaid, **you will need to bring your current Medicaid Indentification Card to each visit. These cards are valid for only one month at a time, so it is very important to bring the current month card to your visit.** Failure to bring the current card may result in your appointment being rescheduled. If there is a co-pay with your plan, you will be expected to pay it at the time of service.

HEALTH SAVINGS ACCOUNTS/HEALTH REIMBURSEMENT ACCOUNTS are being promoted so that patients can have more control over managing their health care spending. These accounts will be patient specific so it is important you are aware of all benefits, deductibles, and co-payments. The deductible and co-payment will be expected at the time of service.

SELF PAY PATIENTS are those patients who **do not have any insurance coverage**. Self pay patients will be given a 20% discount off the charges for services provided, if the patient pays their bill in full at the time of service. The discount does not apply to billed services. This discount also does not apply to those patients who may have insurance, but we do not participate with their plan.

MEDICAL LEAVE/DISABILITY FORMS will be completed within 7 to 10 business days upon receiving the form in the office. Please make sure you allow plenty of time for completion of these forms. Emergencies will be handled on a case by case basis. There may also be a fee for completion of these forms.

We thank you for taking time to read and understand our policies. Please let us know if you have any questions. Again, our office should be notified immediately of any changes in insurance coverage or primary care assignment.

I understand my responsibilities as outlined above and will abide by them.

Patient/Guardian Name _____

Patient/Guardian
Signature_____ Date_____