WILLOW
WOMEN'S HEALTH

2840 Legacy Drive, Suite 400
Frisco, TX 75034
(P) 469-476-5623; (F) 469-476-5624

Please print clearly so that we can process your information quickly and efficiently. Thank you!

CONSENT FOR TREATMENT - FINANCIAL RESPONSIBILITY

I, the undersigned, consent to treatment necessary for the care of the above-named patient. I hereby authorize release of any or all medical records to referring physicians, my insurance carriers, or those involved in payment of my account. I give Willow Women's Health, LPC. and its employees and/or agents "express prior consent" to contact me at any/all phone numbers, including cell phone numbers (by phone call, text message, or e-mail), for the purpose of treatment, insurance, unpaid balances, and/or payment.

I further acknowledge full financial responsibility for any services rendered by Willow Women's Health, LPC. and understand that payment of charges incurred in the office is due at the time of service. I also understand that charges not covered by insurance remain my responsibility and assign insurance benefits to Willow Women's Health, LPC. In the event an account is not paid within 90 days, the undersigned agrees to pay all costs of collection including attorney's fees and court costs (33%) and hereby waives all right of exemption under the constitution of the State of Texas.

Your physician is here to provide you with the best care possible. If services, that your physician feels necessary for the treatment of your condition and maintenance of good health are NOT covered by your insurance health benefits contract, you are expected to pay for those services in full. If you have any questions about whether or not a particular service is covered by your health benefits contract, someone in our office will be happy to assist you.

Our practice firmly believes that a good physician/patient relationship is based upon understanding and good communications. Questions about financial arrangements should be directed to the physician's office manager. Please sign below that you have read and agree to this financial policy.

_____ _____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY **DATE**

SIGNATURE OF CO-RESPONSIBLE PARTY **DATE**

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OFFICE POLICIES

Please read each office policy carefully. We hope this information is helpful to you when accessing our office and making decisions about your health.

Registration: All patients are required to complete a patient information form and present a valid form of identification along with their insurance card before being seen by a provider.

Charges: Full payment is due at the time of service unless other payment arrangements have been made. Copays, deductibles, co-insurance, and balances are also expected at the time of service. Delays in insurance occur when insurance information is not provided in a timely manner. Such delays may also result in insurance not covering the services provided. **When an insurance company denies payment for a service, it is the patient's responsibility to cover the charges. Therefore, it is important to review your benefits with your insurance provider. In the event your insurance plan determines a service to be "a non-covered service", you will be responsible for all non-covered and allowable charges.**

No Show/ Cancellation: Patients with two (2) no show appointments will be charged a $50.00 fee and receive a no-show letter. Patients who do not give a 24-hour cancellation notice or cancel at the last minute may also be charged a $50.00 fee. This fee is not payable by your insurance company. Our office attempts to make courtesy reminder calls, however, we cannot always provide this service. It is the patient's responsibility to remember their appointment time and date. Patients who have three no shows will be subject to dismissal.

Late Arrivals: Patients who arrive ten (10) minutes past their appointment time may be rescheduled for another day.

FMLA/Disability Forms: Any patient needing forms to be filled out for FMLA or Short-Term Disability will be charged a $25.00 processing fee. This fee must be paid before the forms can be picked up, faxed, or mailed out. Please allow 5-7 business days for the forms to be filled out. There is a $50 processing fee for expedited requests. This fee is not payable by your insurance company.

Medication Refills: Refill requests should be called into your pharmacy at least five (5) business days before the last pill is taken to allow adequate time for approval. Refills will only be handled during normal business hours, Monday through Friday. Narcotic prescriptions will not be refilled after hours or on the weekends.

Referrals: Please allow five (5) business days to process any non-urgent referrals.

Behavior: Physical and verbal abuse towards office staff will not be tolerated. This includes offensive behavior on the telephone with office personnel. Abusive behavior may result in immediate dismissal from the practice.

Patient Portal: While we encourage the use of the portal, please be aware that portal messages will NOT be answered after office hours, on weekends, or on holidays. Please use the main office phone number for emergencies/urgent matters.

_____ _____

Signature of Patient or Guardian/Relationship **Date**

_____ _____

Printed name of Patient or Guardian/Relationship **Date of Birth of Patient**

Release of Information

Patient Name:_____

Previous name used : _____

Date of Birth _____

I hereby Authorize: (Please circle your practice)

Inspire Health	Willow Women's Health	Sleep Medicine Of DFW
469-200-6100	469-476-5623	(469) 361-2784
Fax: 469-200-6101	Fax: 469-476-5624	Fax: (469) 200-6101

INSPIRE HEALTH

WILLOW WOMEN'S HEALTH

Sleep Medicine of DFW

To obtain Medical Records from:

Physician or Business name : _____

Address:_____

Phone Number _____ Fax:_____

To release Medical records to:

Physician or Business name : _____

Address:_____

Phone Number _____ Fax:_____

Information to be requested or released for the purposes of:

- ☐ Complete Records
- ☐ Care Plan
- ☐ Lab Reports
- ☐ Medication Record
- ☐ Treatment Record
- ☐ Pathology Reports
- ☐ Hospital Reports
- ☐ Other (please specify)_____

Patient Signature_____

Date:_____ Printed Name_____

HIPAA Compliance Patient Consent

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. The notice is available upon request or can be reviewed in our office. The terms of the notice may change, if so, you will be notified at your next visit to update your signature and date. You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations. By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? ☐ Yes ☐ No

May we leave a message on your answering machine at home or on your cell phone? ☐ Yes ☐ No

May we discuss your medical condition with any member of your family? ☐ Yes ☐ No

***If YES**, please provide name, relationship, and number*

1._____

2._____

Patient/Parent/Legal Guardian Signature:_____

Patient/Parent/Legal Guardian Print Name:_____

Date:_____

Please notify us if you would like a copy of the HIPAA Notice Privacy Practices for your records.

WILLOW WOMEN'S HEALTH

Dr. Shruti Benjamin

Patient name:
DOB:
Date:

New Patient Intake Form

OB HISTORY

Total Number of Pregnancies: _____ Abortions: _____ Miscarriages: _____

Premature births: _____ Live births: _____ Living children: _____

List *all* pregnancies:

Date	Vaginal/Cesarean (V/C)	# weeks pregnant	Baby's weight	M/F	Complications

GYN HISTORY

Date of last menstrual period:_____

Age of first menstrual cycle? _____

Are your cycles regular? _____

How many days do they last? _____

Date of last pap smear?_____

Have you had any abnormal pap smears?

Yes No

Have you received the HPV vaccine?

Yes No

Are you currently sexually active? _____

If not, have you ever been sexually active?

Yes No

At what age was your first intercourse? _____

# of sexual partners? _____

Do you currently have a partner? _____

Men Women Both

Have you ever been treated for sexually transmitted infections?

Yes No

If yes, when? _____

If yes which one: Gonorrhea, Chlamydia, Syphilis, Herpes, Condyloma, PID

Have you ever been sexually abused, threatened or hurt by anyone?

_____

Have you ever been tested for HIV?

Yes No Result? Neg Pos

If in menopause, at what age did it occur?

_____

Years of hormone replacement therapy?

_____

Date of last mammogram? _____

Have you had any abnormal mammograms?

Yes No

If yes, when? Month/Year_____

Have you had any breast biopsies?

Yes No

Result:_____

Current Method of Birth Control:_____

Previous Birth Control Methods: _____

WILLOW WOMEN'S HEALTH

Dr. Shruti Benjamin

Patient name:
DOB:
Date:

MEDICAL HISTORY: List all medical problems (Ex: High blood pressure, diabetes, hypothyroidism, etc):

_____ _____
_____ _____
_____ _____

Have you had a blood transfusion? Yes No **If yes, when:** _____

MEDICATIONS (including over the counter medications and supplements)

Name:	**Dose:**
_____	_____
_____	_____
_____	_____
_____	_____

List any medications or foods that you are ALLERGIC to (and the reaction):

Name:	**Type of Reaction:**
_____	_____
_____	_____

SURGICAL HISTORY: List any surgeries you have had and the approximate date:

_____ _____
_____ _____
_____ _____

SOCIAL HISTORY

Occupation: _____

# of Children: _____

Pets: _____

Tobacco: yes no quit #cigarettes/day _____ #years _____ Years quit: _____

Alcohol yes no quit #drinks per day/week _____ type _____

Drugs yes no quit _____

Exercise yes no #times/week _____ type _____

Seat belt use yes no

FAMILY HISTORY: List any MEDICAL CONDITIONS of your relatives (Parents, siblings, children):

Diabetes	yes	no	Who: _____
Hypertension	yes	no	Who: _____
Thyroid disease	yes	no	Who: _____
Osteoporosis	yes	no	Who: _____
Blood clots	yes	no	Who: _____
Cancer:			
Breast	yes	no	Who: _____
Uterine	yes	no	Who: _____
Ovarian	yes	no	Who: _____
Colon	yes	no	Who: _____
Other: _____			

Other: _____