Axia Women's Health

Patient Demographic Form

Patient Information

Last Name: _____ First Name: _____ Today's Date: _____

Other Name: _____ Date of Birth: _____ Soc. Sec. No: _____

Address (street): _____ City, State, Zip: _____

Email Address: _____ Home Phone: _____

Cell Phone: _____ Work Phone: _____ Ext _____

PCP: _____ Address (street): _____

City, State, Zip: _____ PCP Tele #: _____

Birth Sex: ☐ Male ☐ Female **Gender Identity:** ☐ Male ☐ Female ☐ Genderqueer, neither exclusively male nor female

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Partner

Preferred Language: ☐ English ☐ Spanish ☐ Other _____

Race: ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander ☐ Asian ☐ Black or African American

☐ White ☐ Refuse to Report **Ethnicity**: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Refuse to Report

Emergency Contact

Name: _____ Relationship: _____ Phone: _____

Electronic Communications

Email: I understand Axia Women's Health will **not** share my email address with any third-parties. My address will be used to communicate important announcements about my care center or provider, such as office closings, changes in services, and other non-clinical announcements pertaining to Axia or my care center. Axia offers secure electronic communications between patients and their office via the Patient Portal.

☐ Yes, I want to participate. Please use the email address above. ☐ No, I do not wish to participate.

Automated Reminders: Axia Women's Health offers automated reminders via text messages or automated calls. If I choose to participate, I understand my cell phone listed above will be used.

☐Yes, I agree to participate. (Please choose one method) | Text messages | Voice calls

☐No, I **do not** wish to participate.

I agree that Axia Women's Health and/or its agents may contact me by cell phone, including via text messages or automated calls, which may result in charges to me.

e-Prescription Consent for Medication History

With my consent, Axia may request and use my prescription medication history information using their e-prescription feature. This is for only informational purposes, so an up-to-date record of my medication is available for my treatment and safety.

☐ Yes, I give consent to obtain my medication history using the e-Prescribing feature.

☐ No, I do not give consent to obtain my medication history using the e-Prescribing feature. I understand that my medication information may not be complete when making treatment decisions.

Insurance Information

Primary Carrier Name: _____ Telephone #: _____

Address: _____ City, State, Zip: _____

ID/Cert #: _____ Group/Plan #: _____ Effective Date: _____

Secondary Carrier Name: _____ Telephone #: _____

Address: _____ City, State, Zip: _____

ID/Cert #: _____ Group/Plan #: _____ Effective Date: _____

Pharmacy Information

Pharmacy Name: _____ ☐ Local ☐ Mail away Address: _____ City, State, Zip:

Phone: _____ Fax: _____

Pharmacy Name: _____ ☐ Local ☐ Mail away Address: _____ City, State, Zip:

Phone: _____ Fax:

Employment Information

Employer: _____ Employer Address (street):_____

City, State, Zip: _____

Emp. Status: ☐ Full-Time ☐ Part-Time ☐ Not Employed ☐ Self-Employed ☐ Active Military

Student Status: ☐ Full-Time Student ☐Part-Time Student

Additional Information

How did you hear about our practice? Please check all that apply:

☐ Advertisement- Print or Magazine ☐Community Event/Presentation ☐ Google or another Search Engine

☐ Advertisement- Billboard ☐ Insurance Directory ☐ Social Media ☐ Signage/Drive-by ☐ Website

☐ Advertisement- Online ☐ Referral from friend or relative ☐Referral from a provider. Who: _____

_____ _____

SIGNATURE OF PATIENT OR REPRESENTATIVE DATE

Axia Women's Health

Telemedicine Consent

Introduction
Telemedicine involves the use of electronic communications to provide healthcare services to you. This may include use of a patient portal, tablet or smart phone to share information about you with your healthcare provider or by your healthcare provider. The information may be used for consultation, diagnosis, therapy, follow-up and/or education, and may include any of the following:

- Patient medical records
- Medical images
- Live two-way audio and video
- Output data from medical devices and sound and video files

Electronic communications will be performed through a third-party software and system that includes security safeguards to protect the confidentiality of your information and will include measures to safeguard the data.

Expected Benefits:

- Improved access to medical care that may enable a patient to remain at home and consult with or receive treatment by a physician or other healthcare provider from their office.
- More efficient medical evaluation and management.
- Obtaining expertise of a distant specialist.

Possible Risks:
There are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the physician and consultant(s);
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment;
- In very rare instances, security safeguards could fail, causing a breach of privacy of your information;
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgment errors.

Notice of Privacy Practices:

- Our Notice of Privacy Practices may be found at https://axiawh.com/
- The Practice will use or disclose your information only as permitted by its Notice of Privacy Practices.

By signing this form, I understand the following:

1. On March 11, 2020, the World Health Organization declared the COVID-19 (Novel Coronavirus) viral disease to be a pandemic and recommending social distancing to help slow the spread of the virus. I understand that it is within this context that I am being offered "telehealth", rather than a face-to-face visit. I understand potential risks and limitations of this mode of treatment (including, but not limited to, the absence of in-person examination) and agree to be treated in a remote fashion in spite of them.

2. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent.
3. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.
4. I understand that I have the right to inspect all information obtained and recorded in the course of a telemedicine interaction and may receive copies of this information for a reasonable fee.
5. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. Some services may only be available by telemedicine. My healthcare provider has explained the alternatives to my satisfaction.
6. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.
7. I understand that it is my duty to inform my physician of electronic interactions regarding my care that I may have with other healthcare providers.
8. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.
9. I understand that I should contact my physician for worsening conditions or problems, and seek emergency medical treatment and/or call 911 as necessary.

_____

Patient or Guardian Signature Date

_____

Printed Name Relationship