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

Medical History Form

Axia WOMEN'S HEALTH

Name:	DOB: / /	Date:

LIMITATION TO CARE: ☐ Disability:

Translator Needed: ☐ Spanish ☐ American Sign Language ☐ Other:

Other Preferences:

CURRENT MEDICATIONS: List all Current and Over the Counter Medications

MEDICAL HISTORY: Select all that apply

☐ Alcohol Abuse ☐ Anemia ☐ Anxiety Depression ☐ Arthritis ☐ Autoimmune Disorder ☐ Blood Transfusion ☐ Breast Problems ☐ Cholesterol ☐ Clotting Disorder ☐ Diabetes	☐ DVT/PE ☐ Eating Disorder ☐ Endometriosis ☐ Fibroids ☐ GI Issues ☐ Heart Disease ☐ Hepatitis/Liver Disease ☐ High Blood Pressure ☐ Kidney Disease	☐ Kidney Stones ☐ Lung Problems ☐ Migraine Headaches ☐ Osteoporosis ☐ Polycystic Ovarian Syndrome ☐ Stroke ☐ Substance Abuse ☐ Thyroid Disease ☐ Other: Please Specify _____	☐ Breast Cancer ☐ Cervical Cancer ☐ Colon Cancer ☐ Endometrial Cancer ☐ Ovarian Cancer ☐ Rectal Cancer ☐ Uterine Cancer ☐ Other: Please Specify _____

ALLERGIES: List All Known Drug Allergies

☐ No Known Drug Allergies		

GYN HISTORY

GYN Testing: answer all that apply

▪ Last Pap Smear	/ /
▪ Result of Last Pap Smear [ ] Normal [ ] Abnormal [ ] No pap ever	
▪ Last HPV Testing	/ /
▪ Last Colposcopy	/ /
▪ Last Mammogram	/ /
▪ Last Pelvic Ultrasound	/ /
▪ Last Colonoscopy	/ /
▪ Date of Last Bloodwork	/ /

MENOPAUSE: if menopausal

▪ Began at age:	years old

▪ **Current Menopausal Symptoms:**
[ ] None [ ] Hot Flashes [ ] Memory Loss
[ ] Headache [ ] Irritability [ ] Weight Gain
[ ] Loss of Libido [ ] Vaginal Dryness
[ ] Other: please specify

▪ **Treatment:** [ ] None [ ] Hormone [ ] OTC

SELF-BREAST EXAMINATION

▪ **Do you perform Self-Breast examinations?**
[ ] Monthly [ ] Sometimes [ ] Do not perform

MENSTRUATION: if menopausal skip

▪ **Age of Onset:** At what age did your periods start?	yrs old
▪ **LMP:** What was the date of your last period?	/ /

▪ **Time Between Periods:**
[ ] Irregular [ ] 21-32 days apart [ ] < 21 days apart
[ ] 33-44 days apart [ ] > 45 days apart

▪ **Duration:** How long does your period last?
[ ] < 7 days [ ] 2-7 days [ ] 3 days

▪ **Pad or Tampon use per day:**
[ ] 1-3 per day [ ] 4-6 per day [ ] 7 + per day

▪ **How would you describe your period?**
With: [ ] severe pain [ ] mild discomfort [ ] moderate pain
[ ] without moderate pain [ ] light [ ] heavy

MENSTRUAL SYMPTOMS: select all that apply

[ ] None [ ] Headaches [ ] Bloating [ ] Irritability
[ ] Migraines [ ] Weight Gain [ ] Mood Swings [ ] Nausea

▪ Cramping : [ ] Mild [ ] Moderate [ ] Severe

Medical History Form

Name:	DOB: / /

BIRTH CONTROL: please specify

☐ None	☐ Nexplanon	☐ Nuva Ring	☐ Kyleena IUD
☐ Condoms	☐ Diaphragm	☐ Bilateral Tubal Ligation	☐ Liletta IUD
☐ Depo Provera	☐ Ortho Evra Patch	☐ Vasectomy	☐ Mirena IUD
☐ Oral Contraceptives	☐ Spermicide	☐ Withdrawal method	☐ Paragard IUD
			☐ Skyla IUD

SEXUAL ACTIVITY: please specify

☐ Currently sexually active		☐ Not currently sexually active	
▪ Age of first sexual activity	years old	▪ Total # of Lifetime Partners	please specify: _____

Currently or in the past, I have had sex with: [ ] Men [ ] Women [ ] both, Men and Women

Have you been trying to get pregnant without success? ☐ Yes ☐ No

SEXUALLY TRANSMITTED INFECTIONS (STI'S): please specify

[ ] None [ ] Human Papilloma Virus (HPV) [ ] Chlamydia [ ] Herpes Simplex Virus (HSV) [ ] Gonorrhea [ ] Syphilis
[ ] Trichomoniasis [ ] Hepatitis B [ ] Hepatitis C [ ] Human Immunodeficiency Virus (HIV)

URINARY INCONTINENCE

Do you ever leak urine you cough, sneeze, laugh, or exercise?	☐ Yes	☐ No
Do you ever leak urine on the way to the bathroom or can't get to the bathroom on time?	☐ Yes	☐ No
Do you go to the bathroom frequently more than seven times a day and/or get up more than two times at night?	☐ Yes	☐ No

Other:

OB HISTORY

Total # of Pregnancies		Total Living Children	
Number of full-term pregnancies (37 weeks or greater)		Number of preterm Pregnancies (less than 37 weeks)	
Number of Miscarriages/Abortions		Number of Ectopic (tubal) Pregnancies	

Please fill out the following to the best of your recollection regarding your prior pregnancies:

	Date MO/YEAR	SEX	GA WEEKS	TYPE of DELIVERY	BIRTH WEIGHT	ANESTHESIA	LENGTH of LABOR	WEIGHT GAIN
Preg 1		M F		Vaginal C-Section	lbs. oz.			
Comments and complications:								
Preg 2		M F		Vaginal C-Section	lbs. oz.			
Comments and complications:								
Perg 3		M F		Vaginal C-Section	lbs. oz.			
Comments and complications:								
Preg 4		M F		Vaginal C-Section	lbs. oz.			
Comments and complications:								

Medical History Form

Axia WOMEN'S HEALTH

Name:	DOB: / /

SURGICAL HISTORY: In Date Order, please list all surgeries and c-sections (including minor surgery)

☐ Denies Past Surgical History

Mo/Year	Type of Surgery

HOSPITALIZATION: Please list any hospitalization

☐ Denies any Hospitalization ☐ See Surgical History Above

Mo/Year	Please Specify:

FAMILY HISTORY: Please check all that apply for the corresponding family members by placing an "X" in the appropriate boxes.

☐ **Patient Adopted**

	Heart	Diabetes	Hypertension	Breast	Ovarian	Heart	Colon	Stroke	Mental Illness
Mother									
Father									
Maternal Grandmother									
Maternal Grandfather									
Paternal Grandmother									
Paternal Grandfather									
Daughter									
Son									
Sister									
Brother									

List all other Family Genetic Disorder(s) and specify the relationship:

SOCIAL HISTORY

Tobacco: Are you a Tobacco Smoker? ☐ Non-Smoker ☐ Yes, Current Smoker ☐ Former Smoker

If *yes*, please answer the following:

How often do you smoke cigarette's? ☐ Everyday ☐ Somedays, but not everyday

If "current smoker": How many cigarettes a day do you smoke?

☐ 5 or less ☐ 6-10 ☐ 11-20 ☐ 21-30 ☐ 31 or more

Are you interested in quitting? ☐ Ready to quit ☐ Thinking about quitting ☐ Not ready to quit

Non-Tobacco Use: I am *not* using tobacco, but I am currently:

☐ using an E-Cigarette ☐ Vaping ☐ using Marijuana

Medical History Form

Axia WOMEN'S HEALTH

Name:	DOB: / /

SOCIAL HISTORY

Alcohol:

- Did you have a drink containing alcohol in the past year? ☐ Yes ☐ No
- If yes, how often did you have a drink containing alcohol in the past year?

☐ Never ☐ Monthly or less ☐ 2-4 times a month
☐ 2-3 times a week ☐ 4 or more times a week

Drugs

- Have you used drugs other than those for medical reasons in the past year? ☐ Yes ☐ No
- **If yes, please select all that applies:**

☐ Heroin ☐ PCP ☐ Prescription Opiates ☐ LSD
☐ Cocaine ☐ Ketamine ☐ Ecstasy ☐ Crack
☐ Marijuana ☐ Methamphetamine

- If yes, How many months ago did you use? [ ] months ago
- Are you in a treatment program? ☐ Yes ☐ No
- Have you ever injected drugs? ☐ Yes ☐ No
- Are you still using? ☐ Yes ☐ No
- Is there a minor 18 years or younger at home? ☐ Yes ☐ No
- How many children at home under 18 years old? ☐ Yes ☐ No

Miscellaneous:

Occupation:

Please describe Caffeine Intake:

☐ None ☐ 1-2 cups per day ☐ 2-3 cups per day
☐ 3-4 cups per day ☐ More than 4 cups per day

Any history of domestic violence?

☐ None ☐ History in the past ☐ Has restraining order
☐ Feels unsafe at home ☐ Have safety plan

Any history of verbal abuse?

☐ None ☐ Occasional ☐ Frequent
☐ Seeking Counseling ☐ Has safety plan

- Has your partner ever threatened you or made you feel afraid? ☐ Yes ☐ No
- Does your partner or someone important to you hurt you physically or emotionally? ☐ Yes ☐ No

IMMUNIZATIONS: Have you had any of the following?

Chicken Pox	☐ Yes	☐ No	Year	Hepatitis B	☐ Yes	☐ No	Year
DTAP	☐ Yes	☐ No	Year	Pneumonia	☐ Yes	☐ No	Year
Flu	☐ Yes	☐ No	Year	Rubella	☐ Yes	☐ No	Year
Gardasil	☐ Yes	☐ No	Year	Tetanus	☐ Yes	☐ No	Year

Would you object to blood products in the event of an emergency?

- Choose one: ☐ No, I will not object to blood products. ☐ Yes, I will object to blood products.

Patient Name: (please print)	Date
Patient Signature:	

Premier Women's Health of South Jersey

an Axia Women's Health Care Center

Financial Policies and Procedures

Thank you for choosing Premier Women's Health of South Jersey, an Axia Women's Health Care Center, for your care. In the last few years we have noticed an increase in the number of patients with insurance coverage which includes a substantial deductible or large uncovered portion in their benefit plan. We recognize that in the recent economic climate, many patients have also lost insurance through their employer. We hope the information below will provide a clear understanding of our policies and your options in these situations. In doing so, we can then focus on your clinical care. Our administrative staff is available for any other specific questions regarding insurance and financial matters.

Insurance Plan Participation

We participate in a variety of insurance plans and our group considers new options regularly. Our staff will verify your insurance plan coverage, provided we participate with your plan. Please have your insurance card available so you can provide the most current information to our staff when making your appointment. This will ensure that your claims are submitted to the correct insurance plan.

Documentation of Insurance

We ask all our patients to complete our patient information forms prior to their appointment. Our staff will provide instructions for completing the forms. On the date of your appointment, we will need your current insurance card for proof of coverage benefits. Please also bring a valid driver's license or other valid photo identification.

Processing Your Insurance Claims

We will submit your claims to the insurance plan you have provided at the time of your visit. If your insurance changes during the course of your care, it is your responsibility to provide us with the correct information. If we do not receive the correct information in a timely manner you may be responsible for the entire balance of your insurance claim. In processing your claims, the insurance company may need you to supply certain information before they will pay the claim. It is your responsibility to comply with their request.

Services Not Covered by Your Insurance Plan

Please understand your insurance coverage is a contract between you and the insurance company. Any disagreements or disputes regarding your specific benefits should be directed to the insurance plan or your employer's Human Resource Department.

Plan Co-payments, Deductibles and Health Savings Accounts

- Plan Co-payments – It is our policy to collect all plan co-payments at the time of your visit. Certain types of exams or testing may not require a copayment. We cannot always determine this for every insurance plan. If we collected a co-payment in error, the amount will be refunded to you after we have received notification from your insurance plan.
- Health Savings Accounts, Deductibles or Co-insurance Patient Responsibility – You will receive a statement for any portion of our services that is your responsibility after the claim has been processed by your insurance company. We will make every effort to verify your benefits for certain procedures such as surgical procedures or special testing. We may provide you with the estimated amount and a written agreement.

Many patients are being told by their insurance carriers that health care providers are not permitted to collect any balance amount in advance or at the time of service. This is not always correct. If permitted by the insurance plan, and we know the contracted payment amount we will receive and what percentage of that amount you will be responsible for, then we can advise you of the balance and prepare a payment plan.

- If our contracted payment amount changes or your benefits changed and we collect more than the amount due, the excess amount will be refunded to you.
- If you have any balances on other services we have provided, the excess amount will be applied to those services before any refunds are issued.
- If we collected less than the amount due, you will be billed for any balance due upon receipt of payment from the insurance plan.

Obstetrical Care (if applicable)

We make every attempt to verify your benefits for maternity. Maternity benefits include your routine prenatal visits, the delivery, and your 6 week post-partum visit. This is known as global care. Any services such as ultrasounds, lab tests, or other testing done at our office, at the hospital or by other specialists may not be covered, or only a portion may be covered by your plan. We will contact you or review this information at a scheduled visit. Based on your specific financial responsibility, a payment agreement may be provided for you to review and sign. We can provide the payment plan to you so you can better manage the estimated cost during pregnancy.

In the unfortunate situation that your insurance is terminated any time during your pregnancy, please notify our office immediately.

Collection Policy for Non-Payment of Services

Failure to pay any outstanding balance may result in your account being forwarded to a collection agency. Please contact Axia Women's Health's Central Billing Office at (856) 669-6025.

Questions About Your Account

We are available to assist you with a billing, referral, or insurance question. Please call our main number during regular business offices.

If you receive a statement from a Lab such as Quest or LabCorp, or any bill from the hospital, please contact the customer service number on the statement.

Axia Women's Health

Patient's Name: _____ DOB: _____

Authorization for Treatment & Payment of Medical Benefits
Patient Financial Responsibility

Thank you for choosing our practice, an Axia Women's Health Care Center, as your healthcare provider. We appreciate the confidence you have shown by your choice and are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our authorization for treatment, payment, and patient financial policies. If you would like to receive a more detailed explanation of our financial policies, please request a copy.

Authorization for Treatment & Payment of Medical Benefits

I give permission to the practice to provide medical services for diagnosis and treatment. I authorize the release of medical information necessary to process any claims for services rendered and for payment from my insurance company to be made directly to the practice.

Use of Photography

I agree that any photo identification taken at the time of my appointment will be considered a part of my medical record and will be used solely for the purpose of identification.

Patient Financial Responsibilities

- I (or patient's guardian, if a minor) understand that I am ultimately responsible for the payment of my treatment and care.
- You will assist me by billing my contracted insurers. However, I understand that I am required to provide you with the most correct and updated information about my insurance, and I will be responsible for any charges incurred if the information provided is not correct or updated.
- I understand that I am responsible for the payment of copays, coinsurance, deductibles, and all other procedures or treatment not covered by my insurance plan. I understand that payment is due at the time of service, payable by cash, check, and most major credit cards. Patient Responsibility and Benefit information provided by Axia Women's Health are based on information provided by your insurer at the time of service. Axia is not responsible for the accuracy of this information. ACTUAL AMOUNT DUE TO AXIA WILL BE PROVIDED ONCE CLAIM IS ADJUDICATED BY PAYER.
- I understand that I may incur, and am responsible for, the payment of additional charges. These charges may include (but are not limited to):
    - Charge for returned checks.
    - Charge for the copying and distribution of patient medical records.
    - Charge for forms completion.
    - Charge for missed appointments.

Patient Authorizations

- By my signature below, I hereby authorize the practice, an Axia Women's Health Care Center, to release medical and other information to the necessary insurance companies and third-party payers required for payment of rendered health services.
- By my signature below, I hereby authorize assignment of financial benefits directly to the practice, an Axia Women's Health Care Center. I understand that I am financially responsible for charges not covered or denied in full or in part by my insurance plan(s).

I have read, understand, and agree to the provisions of this Authorization for Treatment & Payment of Medical Benefits and Patient Financial Responsibility Form:

_____

Signature of Patient or Guardian Date

Axia
WOMEN'S HEALTH

227 Laurel Road
Echelon One, Suite 300
Voorhees, NJ 08043
P (856) 669-6050

450 Cresson Blvd
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P (484) 831-0200

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability and Accountability Act of 1996 and its implementing regulations (HIPAA), as amended, is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse Protected Health Information (PHI).

This Notice of Privacy Practices describes how we may use and disclose your Protected Health Information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your Protected Health Information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your Protected Health Information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, and conducting or arranging for other business activities. We may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may call your home and leave a message (either on an answering machine or with the person answering the phone) to remind you of an upcoming appointment, the need to schedule a new appointment or to call our office. We may also mail a postcard reminder to your

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home address. If you would prefer that we call or contact you at another telephone number or location, please let us know.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of HIPAA.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization, or Opportunity to Object unless required by law. Use and disclosures of PHI for marketing purposes, as well as disclosures that constitute a sale of PHI, require an authorization from you.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

The Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. If such information is maintained in an Electronic Health Record (EHR), your access rights include the right to a copy in an electronic format. We have the right to charge you a fee for the copying of paper records, and in the case of a request for an electronic copy of your PHI maintained in an EHR (or a summary or explanation of such information) we have the right to charge you the amount of labor costs in responding to your request. Your right to inspect and obtain a copy of your PHI extends only to your PHI contained in our Designated Record Set for you. A "Designated Record Set" is the HIPAA term for medical and billing records and any other records that we use for making health care decisions about you.

You have the right to request a restriction of your health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes described in this Notice of Privacy Practices. Your request must state the specific restriction and to whom you want the restriction to apply. Any such request for restrictions must be in writing, be addressed to the Privacy Officer, and state the specific restriction requested and to whom you want the restriction to apply. However, we are not required to comply with your request, unless you are asking us to restrict the use and disclosure of your PHI to a health plan for payment or health care operation purposes and such information

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you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full.

Your physician is not required to agree to a restriction you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. However, we may condition this accommodation by asking you for information as to how payment will be handled or a specification of an alternate address or other method of contact. We will not request an explanation from you as to the basis for the request. Your request must be in writing, be addressed to the Privacy Officer, and state the specific alternate means or location.

You have the right to obtain a paper copy of this Notice from us, upon request, even if you have agreed to accept this Notice alternatively (i.e. electronically).

You may have the right to have your physician amend your protected health information contained in your Designated Record Set if you believe it is incorrect or incomplete. However, we are not required to make any such amendments. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. All of these documents will be placed in the appropriate part of your Designated Record Set. If you are requesting that we amend your records because you believe that you are a victim of medical identity theft, we will use reasonable efforts to assist you in making corrections to your record which are determined to be appropriate under the circumstances.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. Affected individuals have the right to be notified in the event of a breach of unsecured PHI.

We reserve the right to change the terms of this Notice and will inform you of any changes. You then have the right to object or withdraw as provided in this Notice.

To exercise any of your rights above, please contact our privacy officer in writing.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy officer of your complaint at our office and main telephone number. **We will not retaliate against you for filing a complaint.**

This Notice was originally published and became effective on April 14, 2003, as amended from time to time.

Last Revision April 11, 2017

Axia WOMEN'S HEALTH

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HIPAA Notice of Privacy Practices
Patient Acknowledgement

We are required by law to maintain the privacy of protected health information, and provide individuals with this Notice of our legal duties and privacy practices with respect to protected health information. If you have any questions, please speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Signature below is only acknowledgement that you have been given the option of receiving a copy or been afforded an opportunity to review this Notice of our Privacy Practices:

Printed Name: _____

Signature: _____

Date: _____

Axia Women's Health

HIPAA
Acknowledgments and Authorizations

I. HIPAA Notice of Privacy Practices

Patient Acknowledgment

Axia is required by law to maintain the privacy of protected health information and provide individuals with notice of their legal duties and privacy practices with respect to protected health information. If I have any questions, I understand I can speak with the HIPAA Compliance Officer in person or by phone.

Signature below is only acknowledgment that I have been given the option of receiving a copy or been afforded an opportunity to review Axia's Notice of Privacy Practices:

Print Name: _____ Date of Birth: _____ Date:_____

Signature:_____

II. Authorization for use or Disclosure of Health Information

Patient Contact Information

Home #: _____ Cell #: _____ Work #: _____ Ext: _____

I authorize **brief messages** with medical information to be left on voicemail at (check all that apply): ☐ Home ☐ Cell ☐ Work

I authorize **extended messages** with medical information to be left on voicemail at (check all that apply): ☐ Home ☐ Cell ☐Work

Restrictions/Instructions: _____

Release of Medical History and Treatment Information

I authorize the following individual(s) to receive information pertaining to any medical history and treatment received:

☐Please use my emergency contact on the patient demographic form.

Name: _____ Relationship: _____ Ph #: _____

Name: _____ Relationship: _____ Ph #: _____

The above individual(s) may receive information across all Axia care centers unless otherwise noted:_____

Release of Billing Information

I authorize the following individual(s) to receive information pertaining to any billing issue and to act on my behalf:

☐Please use my emergency contact on the patient demographic form.

Name: _____ Relationship: _____ Ph #: _____

Name: _____ Relationship: _____ Ph #: _____

The above individual(s) may receive information across all Axia care centers unless otherwise noted:_____

Parent / Guardian Information

Contact: _____ Relationship to You: _____

Home Phone: _____ Alt. Phone: _____

Contact: _____ Relationship to You: _____

Home Phone: _____ Alt. Phone: _____

Patient Acknowledgment

In accordance with the Privacy Rule of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, I understand that:

1. I may revoke this authorization at any time, except to the extent where action has already been taken in accordance with the original authorization for disclosure. My revocation must be in writing, signed by me or on my behalf, and delivered to our office address. My revocation will be effective once received by the practice, an Axia Women's Health Care Center.
2. A copy of this authorization may be used with the same effectiveness as the original.

This authorization replaces any prior written authorization I have made regarding the use, release, and disclosure of my medical information.

Print Name: _____ Date: _____

Signature: _____ Relationship: _____

Additional Authorizations

I request a female chaperone to be present during my examination? ☐ Yes ☐ No ☐ Other _____

Axia WOMEN'S HEALTH | PREMIER WOMEN'S HEALTH OF SOUTH JERSEY

axiawh.com

Your Name: _____ Date of Birth: _____

Today's Date: _____

Last Menstrual Period _____

Please list all allergies and type of reaction: _____

_____

_____

_____

Please list all medications that you take, as well as quantity and frequency:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Mullica Hill | 34 Colson Lane, Mullica Hill, NJ 08062 | P: 856-223-8930 F: 855-475-6191
Elmer | 340 West Front Street, Hofmann Professional Building, Suite 201, Elmer, NJ 08318 | P: 856-223-8930 F: 855-475-6191
Woodbury | 603 North Broad Street, Suite 300, Woodbury, NJ 08096 | P: 856-223-8930 F: 855-475-6191
Woolwich | 100 Lexington Road, Building 100, Woolwich Township., NJ 08085 | P: 856-223-8930 F: 855-475-6191

Axia WOMEN'S HEALTH | PREMIER WOMEN'S HEALTH OF SOUTH JERSEY

axiawh.com

Patient Name _____

Date of Birth _____

Dear Patient:

The State of New Jersey mandates that every physician office document any barrier to care including physical impairments, cultural and linguistic needs in their medical records.

Please assist us by answering the following questions:

Do you have any impairment – Visual, hearing, speech, learning, physical or language/cultural barrier?

What language do you speak, read or write?

Do you have any religious or culture customs that the provider should know about?

Patient Signature _____

Date _____