Stephen R. Wells, M.D., APC

a division of Women's Health Partners of California, Inc.

Obstetrics, Gynecology, and Minimally Invasive Surgery

110 Tampico, Suite 220, Walnut Creek, CA 94598 • 925-935-5356 • fax: 925-935-1070 • www.stephenwellsmd.com

Dear Patient,

Welcome to our office! Please take a few minutes to COMPLETELY fill out the following forms so that we may better serve you. Be very accurate and specific and feel free to elaborate on any answers you give.

Please return these forms to us early enough so that we have at least 2 business days to input your information into your electronic medical record. Please MAIL or FAX them back to the number above. If we do not receive your paperwork in advance of your appointment, your wait time in the office may be longer than usual, as we will need to input all of your information prior to you being seen.

We strive to be as efficient as possible and ask for your help to keep your wait time as short as possible. Thank you for working with us! We look forward to assisting you with your gynecologic or obstetric needs!

Sincerely,

Stephen R. Wells, MD

Stephen R. Wells, M.D., APC
a division of Women's Health Partners of California, Inc.
110 Tampico, Suite 220, Walnut Creek, CA 94598 • 925-935-5356 • fax: 925-935-1070 • www.stephenwellsmd.com

PLEASE TYPE INFORMATION, PRINT, BRING TO OFFICE

■ Patient Information

Today's Date _____

Name (Last, First, Middle) _____ **Nickname** _____

Birthdate _____ **Soc. Sec. #** _____ **Home Phone** _____

Email address _____ **Cell Phone** _____

Address _____ **Work Phone** _____

City _____ **State** _____ **Zip** _____

Employer _____ **Occupation** _____

☐ **Check if minor (less than18) Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Referring Physician _____ **Phone** _____

■ Spouse / Legal Guardian

Name (Last, First, Middle) _____

Birthdate _____ **Soc. Sec. #** _____ **Cell Phone** _____

Address _____ **Home Phone** _____

City _____ **State** _____ **Zip** _____

Employer _____ **Occupation** _____ **Work Phone** _____

■ Emergency Contact

Name _____ **Relationship** _____ **Phone #** _____

■ Primary Insurance

Insurance Company/Address/Phone# _____

Insurance ID # _____ **Group #** _____ **Effective Date** _____ **Copay** _____

Please enter the subscriber's information below. If you are the policyholder yourself, check this box ☐ *and skip to the next section.*

Subscriber's Name (Last, First, Middle) _____

Relationship to Patient _____ Soc. Sec. # _____ **Birthdate** _____

Address _____ **Home Phone** _____

Employer _____ **Work Phone** _____

■ Secondary Insurance

Insurance Company/Address/Phone# _____

Insurance ID # _____ **Group #** _____ **Effective Date** _____ **Copay** _____

Please enter the subscriber's information below. If you are the policyholder yourself, check this box ☐ *and skip to the next section.*

Subscriber's Name (Last, First, Middle) _____

Relationship to Patient _____ Soc. Sec. # _____ **Birthdate** _____

Address _____ **Home Phone** _____

Employer _____ **Work Phone** _____

■ Assignment and Release

I hereby authorize payment directly to Stephen R. Wells, M.D., APC of all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered for me or for my dependents. I authorize the doctors and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of my signature on all insurance submissions. I authorize a copy of this document to be used in place of the original. I have read and agreed to the above.

Signature: _____ Date: _____

If the patient is a minor (under 18 years of age), the responsible parent or guardian must sign above, and fill in the information below.

Parent/Guardian Name (print) _____ Relationship to Patient _____

PRIVACY PRACTICES ACKNOWLEDGEMENT AND CONSENT FORM

☐ I have received your Notice of Privacy Practices and/or I have been provided an opportunity to review it.

☐ I agree that messages regarding my appointments, prescription renewals, lab results, and all other Protected Health Information* ("PHI"), may be left for me on voicemail systems and answering machines at the following telephone numbers, in addition to any other numbers provided to you by me:

☐ _____ ☐Home ☐Cell ☐Other_____

☐ _____ ☐Home ☐Cell ☐Other_____

☐ _____ ☐Home ☐Cell ☐Other_____

(If we need to contact you with lab results, please place a check mark next to the preferred contact number, if any.)

☐ I agree that my PHI may be shared with my spouse.

☐ I agree that my PHI may be shared with the following other people:

_____ _____

_____ _____

☐ I understand that I can change any of the foregoing agreements, at any time, by giving written notice to Stephen R. Wells, MD, APC

**as defined in the Health Insurance Portability and Accountability Act of 1996 and its regulations, as may be amended from time-to-time ("HIPAA")*

Patient Name (print) _____

Signature _____ Date _____

If the patient is a minor (under 18 years of age), the responsible parent or guardian must sign above, and fill in the information below.

Parent/Guardian Name (print) _____ Relationship to Patient _____

Stephen R. Wells, M.D., APC

a division of Women's Health Partners of California, Inc.

Patient History Form

NAME: _____ Today's Date: _____

Date of Birth: _____ My Age Today: _____

Please fill out this form as completely as possible

WHICH PHARMACY WOULD YOU LIKE US TO ELECTRONICALLY SEND YOUR PRESCRIPTIONS?

_____PHARMACY on(street) _____IN(city) _____

WHICH MAIL ORDER PHARMACY DO YOU USE (if any)? _____

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING, INCLUDING DOSAGES AND FREQUENCY:

1._____DOSE:_____FREQUENCY:_____
2._____DOSE:_____FREQUENCY:_____
3._____DOSE:_____FREQUENCY:_____
4._____DOSE:_____FREQUENCY:_____
5._____DOSE:_____FREQUENCY:_____
6._____DOSE:_____FREQUENCY:_____

HAVE YOU LISTED ALL OF THE MEDICATIONS YOU ARE CURRENTLY TAKING, WITH DOSE/FREQENCY? ☐YES ☐NO

ALLERGIES:

List all allergies you have to medications with reactions: Are you LATEX ☐Allergic ☐Sensitive

1. _____ Reaction: _____
2. _____ Reaction: _____
3. _____ Reaction: _____
4. _____ Reaction: _____

Have you listed all of your allergies?? ☐YES ☐NO

Gynecologic/Obstetric History:

What form of contraception are you currently using (if any)? _____

Age when periods began: _____ Age when they stopped (if in menopause): _____

Have you ever been pregnant? ☐YES ☐NO

How many times pregnant? _____ Number of: Full Term: _____ Premature: _____

Dates of pregnancies: _____ Miscarriages: _____ Still Births: _____

_____ Ectopic Pregnancy: _____ Abortions: _____

How old are your children? _____

Period comes every _____ days and lasts _____ days.

Have there been any changes to your period recently? ☐YES ☐NO

Do you have painful periods? ☐None ☐Mild ☐Moderate ☐Severe ☐Incapacitating

Medication(s) Used: _____

Do you have PMS? ☐None ☐Mild ☐Moderate

What are your symptoms? _____

How do you treat your symptoms? _____

Are you currently sexually active? ☐YES ☐NO

Number of sexual partners in last year: _____ Last 5 years: _____

Do you have pain with intercourse? ☐YES ☐NO

Date of last Pelvic/ PAP Exam:

Date of last Mammogram:

Date of last DEXA bone scan:

Date of last colonoscopy: _____

LIST All SURGERIES YOU HAVE HAD WITH DATES (month/year)

1._____ 4._____

2._____ 5._____

3._____ 6._____

Past Medical History: Have you ever had?

- ☐ Abnormal PAP Smear
- ☐ HPV
- ☐ Genital Warts
- ☐ Breast Lumps/Nipple Discharge
- ☐ Endometriosis
- ☐ PID
- ☐ Herpes
- ☐ Gonorrhea
- ☐ Chlamydia
- ☐ Trichomonas
- ☐ Pathologic Ovarian Cysts
- ☐ Uterine Fibroids
- ☐ Chronic Urinary Tract Infections
- ☐ Asthma or other Lung Disease
- ☐ Depression, Anorexia, Bulimia
- ☐ Diabetes
- ☐ DVT or Phlebitis
- ☐ Elevated Cholesterol
- ☐ Heart Disease
- ☐ Hepatitis A, B, or C
- ☐ High Blood Pressure
- ☐ Kidney or Bladder Disease
- ☐ Liver or Gallbladder Disease
- ☐ Migraines or other type of Headache
- ☐ Mitral Valve Prolapse
- ☐ Psychiatric Disorder
- ☐ Seizures or other Neurologic Disorder
- ☐ Sickle Cell, Thalassemia
- ☐ Stroke
- ☐ Thyroid Disorder
- ☐ Vision Problems
- ☐ Hearing Problems

ANY OTHER UNUSUAL HISTORY?

_____

_____

_____

Family History: Please include specifically which family member (ie mother, father, brother, sister, grandparent, aunt and maternal/fraternal). For cancer, indicate age when it was diagnosed.

Breast cancer _____

Ovarian cancer _____

Cervical / uterine cancer _____

Colon cancer _____

Osteoporosis _____

Diabetes _____

Hypertension _____

Heart Disease _____

Stroke _____

Sickle cell / Thalassemia _____

Tay-Sachs _____

Inheritable genetic disorder _____

Social History:

Do you smoke? ☐ Yes ☐ No ☐ former

cigarettes / day: ____

Do you drink? ☐ Yes ☐ No

#drinks / day: ___ #drinks / week: __.

Do you think you drink too much? ☐ Yes ☐ No ☐ Maybe

Do you now or have you had an eating disorder?

☐ Yes ☐ No

Exercise (Type / Duration / Frequency):

_____

_____

Stephen R. Wells, M.D., APC

a division of Women's Health Partners of California, Inc.

BILLING and COLLECTION POLICIES

Our goal is to provide you with high-quality and efficient care. There are many details involved in the process of payment for the services that you receive. In order for this process to flow smoothly, it is essential that you understand what information we must share with each other and with health insurance companies, and what both our responsibilities are.

Upon scheduling and registration we require you to provide your medical insurance card (if you have coverage), photo identification, your address, date of birth, and phone number. If you receive health benefits through a spouse, partner or parent, we require you to provide that person's address, date of birth, and phone number as well. Our billing process works better if you provide social security numbers as well.

Health Insurance Cards: Upon scheduling each appointment, our team will ask to verify your insurance information, and will ask to see your insurance card upon check-in at each appointment. Please bring your card to every appointment, and notify the office at your first appointment after if changes. Intentionally failing to notify us of changes to your insurance coverage may constitute fraud, and we may be obliged to report such behavior to the authorities. We will not engage in any fraudulent practices under any circumstances.

Health Insurance Plans: It is your responsibility to understand the provisions of your health insurance plan and coverage. As helpful as we pride ourselves on being, our team cannot be expected to know the details of your particular plan, as we see hundreds of different plans every week. We recommend contacting your carrier prior to receiving services in order to verify your coverage levels and responsibilities.

Authorizations: You are responsible to obtain all necessary referrals, or other required documentation prior to your appointment. If your referring office determines that your plan requires a referral, and you do not provide such referral you may be required to sign a waiver in order to receive services. Additionally, even should our team fail to request such a waiver, you will nonetheless be responsible for all charges that are not paid by your insurance carrier due to lack of authorization. By signing below, you accept these policies.

Copayments: It is our responsibility, as detailed by the terms of our contracts with health insurance companies, to collect any copayment amounts at the time of your appointment. It is your responsibility, as detailed by the terms of your health insurance coverage, to pay any copayment amounts at the time of your appointment. Please have your payment ready upon check-in. By signing below, you accept these policies.

Previous balances and/or deductibles: It is our responsibility, as detailed by the terms of our contracts with health insurance companies we participate with, to bill you for any portion of your treatment that your health insurance carrier assigns to your responsibility. It is your responsibility, as detailed by the terms of your health insurance coverage, to pay any such portion. If you do not remit full payment on any such bills within a reasonable period and with reasonable notice, your account will be sent to collections (and subject to an additional collection fee, interest and/or legal action will be pursued. You may be dismissed as a patient by our practice for failure to meet your financial obligations. By signing below, you accept these policies.

Health insurance non-payment: Services that have not been paid by your health insurance carrier within 60 days of claim submission will become your responsibility to pay in full. Should your health insurance carrier later pay us for those services you paid for, you will be reimbursed. By signing below, you accept this policy.

Self-pay patients: If you do not have health insurance, have coverage through a carrier with which we do not participate, or are receiving a known non-covered service, it is our policy that you must pay for your service in full before leaving the office. By signing below, you accept these policies.

I have read, fully understand, accept and agree to comply with all the above policies. I consent to the assignment of authorized health insurance benefits by my health insurer to Stephen R Wells, MD for any services furnished to me or my dependents.

Signature of Patient_____ Date_____

If the patient is a minor (under 18 years of age), the responsible parent or guardian must sign above, and indicate relationship to the patient.

Stephen R. Wells, M.D., APC

a division of Women's Health Partners of California, Inc.

ELECTRONIC PAYMENTS: Notice to Patients

In light of the rapidly changing healthcare environment, the vast majority of OB/GYNs in Walnut Creek and a growing number in the San Ramon area have recently merged together into a large fully integrated group, called Women's Health Partners of California, Inc. (WHPCA) as of January 1, 2014. With this merger, come certain responsibilities that we, as a practice must abide by.

As a medical practice our goal is to provide you with the best, most current medical care available in a positive and supportive environment. As a small business we must constantly strive to reduce and minimize our expenses and costs of doing business. Today insurance plans are becoming more complicated in how they determine what the medical practice can collect and what the patient actually owes. Insurance plans now have numerous different co-payments, coinsurances and deductibles that are often confusing to their clients and can even elude the smartest medical practice office manager. What a patient actually owes once insurance pays its portion is a function of the individual's co-payment, coinsurance, deductible, maximum out-of-pocket expenses and where the patient falls within this continuum.

As of March 1, 2014, we are asking every patient to provide us with a credit card, HSA debit card, or a voided check at the time of service. This system is exactly like that found in all hotels, rental car companies, gasoline stations, PayPal, and your mail order pharmacy and will help to make it more cost effective for everybody. **Nothing will be charged to your credit card or checking account until the Explanation of Benefits (EOB) returns from your insurance company and we can enter the contractual write-offs and amount paid by your insurance company into our system**.

The only amount charged to your credit card or checking account will be the PATIENT RESPONSIBILITY portion as defined on your insurance company's EOB (similar to an invoice). **This amount reflects your contractual responsibility based upon the specific insurance plan(s) that you selected**. You will receive an E-MAIL notification three days prior to the amount being charged to your credit card or deducted from your checking account. This will significantly reduce the costs of repeat statements and collection attempts. As a small business operating on fixed insurance reimbursements with rising costs and expenses, we must do everything possible to reduce the length of time that we extend credit to our patients. If you have any questions, please contact Jody Preston, Office Manager.

Thank you for your cooperation and understanding.

NetDeposit® Electronic Payment Authorization Form

COMPANY INFORMATION			
Company Name Stephen R. Wells, MD, a division of WHPCA	Merchant ID 234785		
Street Address 110 Tampico, Suite 220	City Walnut Creek	State CA	ZIP Code 94598

PAYOR INFORMATION			
Name and Title	Phone	Email	
Address	City	State	ZIP Code

PAYMENT INFORMATION (only one account required)		
☐ Charge my Bank Account	☐ Charge my Credit Card/HSA Debit card	
Bank Name:	Card Type: ☐ Visa ☐MasterCard ☐Discover ☐AMEX	
Name on Account:	Card Number:	
RT Number:	Expiration Date:	CVV:
Account Number:		

SIGNATURE AND AUTHORIZATION

I authorize NetDeposit, LLC, on behalf of the Company to debit my account as identified above according to the terms stated here. This authorization shall remain in effect until the company receives written notification by me. I understand that my account will only be debited for "patient responsibility" as identified by my insurance company's Explanation of Benefits (EOB). I understand that I am liable for any bank fees due to Non-Sufficient Funds (NSF). I understand that I can dispute the charge at any time with my credit card company or Modern Payments, Inc., however, the actual amount of the charge can only be disputed with my insurance company.

I have provided a valid email address for notification prior to my account being debited. I acknowledge that I will receive this notification three days prior my account being debited and will have the option to request a different account to be charged and/or I will be able to set up a payment arrangement.

I represent and warrant that I am authorized to execute this payment authorization for the purpose of implementing an electronic payment arrangement for my "patient responsibility." I indemnify and hold the Company, the bank, NetDeposit, LLC, harmless from damage, loss, or claim resulting from all authorized actions hereunder.

Signature	Date
Print Name	Relation to patient
Patient Name if different than above	

HIPAA Privacy Rule of Patient Authorization Agreement

Stephen R. Wells, M.D., APC

Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.508(a))

I, _____ (Patient's Name) understand that as part of my health care, Stephen R. Wells, M.D., originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment;
- a means of communication among the health professionals who may contribute to my health care;
- a source of information for applying my diagnosis and surgical information to my bill;
- a means by which a third-party payer can verify that services billed were actually provided;
- a tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals

I have been provided with a copy of the *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures.

I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review Stephen R. Wells, MD notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

Privacy Rule of Patient Consent Agreement

Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.506(a))

I understand that:

- I have the right to review Stephen R. Wells, M.D.. Notice of Information practices prior to signing this consent;
- That Stephen R. Wells, M.D., reserves the right to change the notice and practices and that prior to implementation will mail a copy of any revised notice to the address I've provided if requested;
- I have the right to object to the use of my health information for directory purposes;
- I have the right to request restrictions as to how my protected health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that Stephen R. Wells, M.D., is not required by law to agree to the restrictions requested.
- I may revoke this consent in writing at any time, except to the extent that Stephen R. Wells, MD, has already taken action in reliance thereon.

Signature of Patient or Legal Representative Witness_____

Printed Name of Patient or Legal Representative Witness_____

Date_____