



**LOUISIANA WOMEN'S  
Healthcare Associates**

**\*Please Print\* PATIENT INFORMATION FORM \*Please Print\***

*In order to control our cost of billings, we request that your portion of our charges for office visits be paid at the conclusion of each visit.*

Doctor		Account No.		Date		
<b>PATIENT</b>  <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	First Name		Middle/Maiden		Last Name	
	Date of Birth		Age			
	Address				Phone - Home	
	City, State and Zip Code				Phone - Cell	
	Name of Employer or School				Phone - Work	
	Employer's Address				Occupation	
	Social Security Number		Referred by		Religious Preference	
	List names of family members who are also patients of your doctor:				E-mail address	
	Spouse's name		Occupation		Date of Birth	
<b>RESPONSIBLE PARTY</b>  <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Other	First Name		Middle/Maiden		Last Name	
	Address				Social Security Number	
	City, State and Zip Code				Home Phone	
	Name of Employer				Work Phone	
	Employer's Address					
	Referred by: <input type="checkbox"/> Family Member <input type="checkbox"/> Friend <input type="checkbox"/> Another Physician <input type="checkbox"/> Web Site <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Advertisement					
<b>IN CASE OF EMERGENCY NOTIFY</b>	Name		Address		Relation	
Phone						
<b>INSURANCE INFORMATION</b>	Type of Plan (Check One)		Co-Pay Amount: _____		Type of Plan (Check One)	
	<input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> POS <input type="checkbox"/> INDEMNITY <input type="checkbox"/> OTHER				<input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> POS <input type="checkbox"/> INDEMNITY <input type="checkbox"/> OTHER	
	Primary Insurance			Secondary Insurance		
	Insurance Address			Insurance Address		
	Policy/Contract No.		Group No.		Policy/Contract No.	
	Name of Policy Holder		Employer		Name of Policy Holder	
	Policy Holder's Soc. Sec. No.		Policy Holder's Date of Birth		Policy Holder's Soc. Sec. No.	
Policy Holder's Date of Birth						
<b>RELEASE OF INFORMATION &amp; FINANCIAL AGREEMENT</b>	<b>PLEASE BRING YOUR INSURANCE CARD TO EACH VISIT</b>					
	<p>I consent to treatment necessary for the above named patient. I authorize the release, via fax if necessary, of all medical records, including any and all records containing HIV and substance abuse, to my insurance company, if applicable. This authorization will remain in effect until revoked by me in writing.</p> <p>Signed _____ Date _____</p>					
	<p>I agree to pay for all charges for treatment and understand that payment is due at the time of service. I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, private insurance, and other health plans to the physician. I further authorize and request insurance payments be made directly to LWHA. I understand I am responsible for all charges not paid by my insurance company. If we are forced to turn your balance over to a collection agency, you will be responsible for the collection and attorney's fees, including court costs. All NSF checks will be subjected to a \$25.00 return check fee. This assignment will remain in effect until revoked by me in writing.</p> <p>Signed _____ Date _____</p>					
<b>ACKNOWLEDGMENT OF PRIVACY PRACTICES</b>	<p>I hereby acknowledge that I have been given the opportunity to review and receive a copy of LWHA's Notice of Privacy Practices.</p> <p>I would like to receive a copy of amended notices. <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Signed _____ Date _____</p>					

**Louisiana Women's Healthcare Associates, LLC  
HEALTH HISTORY FORM**

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Reason for Today's Visit \_\_\_\_\_

**PLEASE LIST**

Allergies	Current Medications	Previous Surgery

**SCREENING TESTS**

Test	Date/Year	Normal	Abnormal	HAVE YOU EVER HAD THE FOLLOWING:	
Pap Smear				<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Seizures
Mammogram				<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Hepatitis/Jaundice
Bone Scan				<input type="checkbox"/> TB	<input type="checkbox"/> Thrombophlebitis/Blood Clots
Colon Cancer				<input type="checkbox"/> Diabetes	<input type="checkbox"/> Sexually Transmitted Diseases
Cholesterol				<input type="checkbox"/> Asthma	<input type="checkbox"/> Any other serious illness/injury

**Personal History:**

Do you eat a well balanced diet? \_\_\_\_\_ Do you smoke? \_\_\_\_\_  
 Do you drink alcohol? \_\_\_\_\_ Do you exercise? \_\_\_\_\_  
 Have you ever been treated for alcoholism? \_\_\_\_\_ Do you feel rested after sleep? \_\_\_\_\_  
 Do you have a history of drug abuse? \_\_\_\_\_ Have you recently experienced domestic violence or feel threatened? \_\_\_\_\_  
 Have you every been treated for drug abuse? \_\_\_\_\_

**Menstrual History:**

Age first period began \_\_\_\_\_ Date last period began \_\_\_\_\_  
 Cycle length (example 28 days) \_\_\_\_\_ Irregular periods? \_\_\_\_\_  
 Number of days of flow \_\_\_\_\_ Bleed between periods? \_\_\_\_\_  
 How old were you when you had your first full term pregnancy \_\_\_\_\_ Heavy flow/clots/cramps? \_\_\_\_\_

**PREGNANCY HISTORY**

Year of Delivery	Full Term Premature Stillborn Miscarriage Abortion C-section Vaginal Del. VBAC	List Complications i.e. High Blood Pressure, Tubal Pregnancy, Gestational Diabetes, etc.	Sex of Child	Weight of Child
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**FAMILY HISTORY**

Family Member	Illnesses or Medical Conditions	Age at Death	Cause of Death
Mother			
Father			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			

**WHO IN YOUR FAMILY (Living or Deceased) HAS OR HAD THE FOLLOWING:**

Cancer	Inherited Diseases	Diabetes
Breast Cancer	Birth Defects	Epilepsy
Ovarian Cancer	Sickle Cell Anemia	Heart Disease
Uterine Cancer	Mental Retardation	High Blood Pressure
Other Female Cancer	Any other inherited diseases	Mental Illness
Colon Cancer		TB (Tuberculosis)



LOUISIANA WOMEN'S  
Healthcare Associates

Acct #: \_\_\_\_\_ Dr. #: \_\_\_\_\_

## FINANCIAL POLICY

The physicians of Louisiana Women's Healthcare Associates (LWHA) are committed to providing the highest quality medical care. To ensure our ability to do so, we have established the following financial policy. This information is provided to prevent misunderstanding concerning payment for professional services.

- **Insurance Card and Driver's License:** LWHA participates with a variety of insurance plans. It is your responsibility to bring your current insurance card and driver's license to every visit to ensure we have the correct filing information. Eligibility for coverage by health insurance plans is not guaranteed until a claim is submitted. If it is determined that you are not eligible for coverage, you will be required to pay in full for all services rendered.
- **Payment Due at Time of Service:** You are required to pay any primary insurance co-payments, deductibles, and/or coinsurance at every appointment. LWHA accepts cash, checks, Visa, Master Card, Discover, and American Express.
- **Self-pay Patients:** are required to pay in full for services rendered at the time of service. If you are unable to pay in full, you must make payment arrangements with a Patient Accounts staff member prior to your appointment.
- **Non-Participating Provider / Secondary Insurance:** As a courtesy, LWHA will file claims to health insurance plans with whom we are not participating providers, however, payment is due in full by the patient at the time of service. LWHA does not assume responsibility for secondary insurance coverage. We will file initially to the secondary carrier as a courtesy, however once filed, you are immediately responsible for the outstanding balance (excluding Medicare or Medicaid), as well as any necessary follow-up on these claims.
- **Referrals:** You are responsible for obtaining any required referrals for treatment. If you do not have the necessary referral prior to your appointment, your visit may be rescheduled or you may be financially responsible.
- **Patient Statements:** will be generated once the outstanding balance is deemed your responsibility. Statements are sent to the guarantor listed on the account. LWHA cannot send more than one statement to multiple addresses in cases of divorce or custody settlements. Regardless of the involved parties, the guarantor will be held financially responsible for the account, and will be held to all components of this financial policy. Statements are generated weekly based on the first letter of the guarantor's last name. A guarantor can expect a statement from our office between 5 and 20 days from the time the balance becomes your responsibility. The guarantor is required to pay any outstanding balance indicated on the patient statement in the "Pay This Amount" box within 30 days of the statement's date. Failure to pay outstanding balances within 30 days will result in the generation of a second statement. If the second statement is not paid in full, or payment arrangements are not made within 30 days of the statement date, the account will be transferred to a collection agency where more rigorous collection efforts will be made, including credit agency reporting. Once transferred to a collection agency, it will be the physician's discretion to permit the patient's return to this office. Appointments will not be made for patients until notification is received from the collection agency that the outstanding balance has been paid in full.
- **Refunds of Overpayments:** will be made monthly, approximately 20 days from the time that the refund request is approved. If there are any other outstanding charges on the account or another account with the same guarantor, the credit will remain on the account until all outstanding charges are paid. Health department regulations prohibit refunds on purchases of any retail items such as cosmetics and maternity products.
- **NSF Checks / Pre- or Post-Dated Checks:** Checks returned for insufficient funds (NSF) will incur a \$25 charge, and the check will automatically be redeposited. If the check is returned a second time, another \$25 service charge, plus the face amount of the check will be charged back to the patient's account, and will be due immediately in an alternate form of payment. LWHA cannot accept pre- or post-dated checks.
- **Care of a Minor:** If the patient is a minor (18 years and younger), a parent/guardian must sign below. The parent, guardian or unaccompanied minor is responsible for any payment due at the time of service, as well as presenting all required referral and insurance information. Proof of full-time student status for dependents ages 18-25 is required in advance of any surgical or obstetrical procedure.

Our practice firmly believes that a positive physician/patient relationship is based upon understanding and good communication. We believe that adherence to this financial policy will further promote this relationship. **Please sign that you have read, understand, and accept the terms of LWHA's Financial Policy.**

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Signature of Patient/Legal Guardian

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Date



## **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.**

Louisiana Women's Healthcare Associates is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about the privacy practices at Louisiana Women's Healthcare Associates, please contact:

Chief Executive Officer  
9000 Airline Highway, Suite 500  
Baton Rouge, LA 70815  
225-201-2000

**Effective Date of This Notice: 04/01/03**

### **I. How Louisiana Women's Healthcare Associates (LWHA) may Use or Disclose Your Health Information**

LWHA collects health information from you and stores it in a chart and on a computer. This is your medical record. The medical record is the property of LWHA, but the information in the medical record belongs to you. LWHA protects the privacy of your health information. The law permits LWHA to use or disclose your health information for the following purposes:

1. Treatment. LWHA may use your health information for treatment and delivery of care. This can include communicating your health information to another healthcare provider, pharmacy, or healthcare facility involved in the services provided to you.
2. Payment. LWHA may use your health information to obtain precertification for procedures performed by LWHA. In addition, your health information may be used to transmit claims for payment to your insurance company.
3. Regular Health Care Operations. During the course of care, your protected health information may be disclosed to other staff members who are directly or indirectly involved in your care.
4. Information provided to you.
5. Notification and communication with family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or in the event of your death. If you are able and available to agree or object, we will give you the opportunity to object before making this notification. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.
7. Required by law. As required by law, we may use and disclose your health information.
8. Public health. As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure.
9. Health oversight activities. We may disclose your health information to health agencies during the course of audits, investigations, inspections, licensure and other proceedings.
10. Judicial and administrative proceedings. We may disclose your health information in the course of any administrative or judicial proceeding.
11. Law enforcement. We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena and other law enforcement purposes.
12. Deceased person information. We may disclose your health information to coroners, medical examiners and funeral directors.
13. Organ donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.
14. Research. We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

15. Public safety. We may disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.
16. Specialized government functions. We may disclose your health information for military, national security, and prisoner benefits.
17. Worker's compensation. We may disclose your health information as necessary to comply with worker's compensation laws.
18. Marketing. We may contact you by telephone or through the mail to provide appointment reminders or to give you information about other treatments or health-related benefits and services that may be of interest to you.
19. Change of Ownership. In the event that LWHA is sold or merged with another organization, your health information/record will become the property of the new owner.

## **II. When LWHA May Not Use or Disclose Your Health Information**

Except as described in this Notice of Privacy Practices, LWHA will not use or disclose your health information without your written authorization. If you do authorize LWHA to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

## **III. Your Health Information Rights**

1. You have the right to request restrictions on certain uses and disclosures of your health information. LWHA is not required to agree to the restriction that you requested.
2. You have the right to receive your health information through a reasonable alternative means or at an alternative location. All requests must be received in writing. LWHA has a form to assist in the transfer of records. In some instances, a charge as defined by law may be levied when necessary for the copying and mailing of your protected health information.
3. You have the right to inspect and copy your health information.
4. You have a right to request that LWHA amend your health information that is incorrect or incomplete. LWHA is not required to change your health information and will provide you with information about LWHA's denial and how you can disagree with the denial.
5. You have a right to receive an accounting of disclosures of your health information made by LWHA, except that LWHA does not have to account for the disclosures described in parts 1 (treatment), 2 (payment), 3 (health care operations), 4 (information provided to you), 5 (directory listings) and 16 (certain government functions) of section I of this Notice of Privacy Practices.
6. You have a right to a paper copy of this Notice of Privacy Practices.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact the Chief Executive Officer as mentioned above.

## **IV. Changes to this Notice of Privacy Practices**

LWHA reserves the right to amend this Notice of Privacy Practices at any time in the future, and to make the new provisions effective for all information that it maintains, including information that was created or received prior to the date of such amendment. Until such amendment is made, LWHA is required by law to comply with this Notice.

When this Notice is revised, it will be denoted on the Notice with the revision date.

## **V. Complaints**

Complaints about this Notice of Privacy Practices or how LWHA handles your health information should be directed to the Chief Executive Officer as mentioned above.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Department of Health and Human Services  
Office of Civil Rights  
Hubert H. Humphrey Bldg.  
200 Independence Avenue, S.W.  
Room 509F HHH Building  
Washington, DC 20201

You may also address your complaint to one of the regional Offices for Civil Rights.  
A list of these offices can be found online at <http://www.hhs.gov/ocr/regmail.html>.