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TIDEWATER PHYSICIANS FOR WOMEN
A Division of Mid-Atlantic Women's Care, P.L.C.

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Patricia Peters, LCSW, ACSW

Patient and Provider Agreement

We are so excited that you have chosen our practice to receive your care. We strive to provide you with excellent medical care and positive customer service. Our team will provide you with our best service possible, and we ask that in return you partner with us to achieve this goal.

To provide you with the best care our office asks you:

- Please attend and arrive on time to recommended and scheduled appointments.
- Please follow through with recommended and scheduled appointments both in our offices and those of any consultant to whom you may be referred. This includes attending any specialty appointments that are recommended I scheduled.
- Please comply with your treatment plan, to include all laboratory testing, ultrasound and other imaging recommendations. For our obstetrical patients, we need your compliance with timing and route of delivery recommendations that are made based on the specific details of your pregnancy.
- Please treat all office staff and medical providers with respect and dignity where in the office(s) or on the telephone.
- Please refrain from verbally abusive behavior, in person and while on the telephone.

_____ _____

Patient Signature Date

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PATIENT INFORMATION RELEASE

Dear Patient:

The Privacy act of 1977 was designed to protect your privacy. It is to give you a feeling of security that when you visit our office, your medical and financial affairs will not be discussed with anyone without your permission. This includes your spouse, family members, friends and employer. In order for us to speak with anyone regarding you, **even in the event of an emergency**, you must specify to whom we may speak.

If you wish for us to be able to release information regarding you, please indicate below. Our staff cannot give out this information without your permission.

I give permission for the staff of Tidewater Physicians for Women to discuss information indicated, regarding myself to:

NAME	RELATIONSHIP	TYPE OF INFORMATION TO BE RELEASED
_____	_____	Medical / Financial
_____	_____	Medical / Financial
_____	_____	Medical / Financial

In the event of an emergency, please contact:

Name: _____Relationship:_____

Home Phone:_____Work Phone:_____Cell Phone:_____

Patient Name:_____***Signature:***_____

Date of Birth:_____***SSN:***_____***Date:***_____

We ask that you update this information annually, or as circumstances change.

Thank You

Updated: _____ _____ _____
Initials/Date Initials/Date Initials/Date

844 Kempsville Road, Suite 208 • Norfolk, Virginia 23502 • (757) 461-3890 • FAX (757) 461-0836
828 Healthy Way, Suite 330 • Virginia Beach, Virginia 23462 • (757) 461-3890 • FAX (757) 467-0301
www.tidewaterobgyn.com

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ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

By signing below, I am acknowledging that I am aware of the HIPAA Privacy Act. I also acknowledge that I have been offered a copy of the Mid-Atlantic Women's Care Privacy Notice pursuant to the Federal regulations known as the HIPAA Privacy Rule. If I am unaware of this, a copy shall be provided to me.

_____
Patient Signature

_____ _____
Patient PRINTED Name Date

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MARKETING AUTHORIZATION FORM

Patient Name: _____ Date: _____

1. Authorizing marketing communication from this practice means I may:

   A. Receive treatment communications concerning treatment alternatives or other health related products or services.

   B. Be contacted for appointment reminders or information about treatment alternatives or other health-related benefits and services that may interest me.

   C. Receive emails or patient portal messages of office E-newsletters or E-blasts.

2. Marketing Authorization Options:

   ☐ I wish to receive Marketing Communications from Tidewater Physicians for Women

   ☐ I do NOT wish to receive any Marketing Communications

I have read the above statements and agree that the office of Tidewater Physicians for Women may send office E-newsletters, E-blasts, communications concerning treatment alternatives or other health related products and services to the email address listed below or patient portal. I understand that I have the right to "opt out" of receiving such communications.

Patient E-Mail Address:_____

Patient Signature: _____

TIDEWATER PHYSICIANS FOR WOMEN
A Division of Mid-Atlantic Women's Care, P.L.C.

FINANCIAL POLICY

Thank you for choosing Tidewater Physicians for Women as your healthcare provider. We are committed to providing you and your family with the best available medical care. In our ongoing process to make sure that all your medical needs are met, our Billing Department will be available to discuss our fees and this policy with you.

We ask that all responsible parties read and sign our Financial Policy as well as complete the Patient Information forms before seeing the physician.

Payments for all services will be due at the time services are rendered. To serve you better, we accept cash, check, Visa, MasterCard, and Discover. As a courtesy to you, Tidewater Physicians for Women will bill your insurance carrier for services rendered. However, you are ultimately responsible for the entire bill. To accurately bill your insurance company, we require that you disclose all insurance information, including primary and secondary insurance, as well as any changes in insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. Any laboratory tests which require an outside lab to perform will be billed separately by that. As the responsible party, please understand:

(PLEASE INITIAL THE FOLLOWING)

___ 1. Your insurance policy is a contract between you, your employer, and the insurance company.We are not a party to that contract. Our relationship is with you, not your insurance company. We will not become involved in disputes between you and your insurer regarding deductibles, co-payments, covered charges, secondary insurance, and "usual and customary" charges. As your medical provider, we will only supply factual information to facilitate claim processing.

___ 2. Fees for services, which include unpaid balances, deductibles, and co-payments, are due at the time of service. Returned checks and outstanding balances may be subject to collection placement and collection fees.

___ 3. All charges are your responsibility, whether your insurance company pays or does not pay. If your insurance carrier does not remit payment within sixty days, the balance will be due in full from you. If any payment is made directly to you for services billed by Tidewater Physicians for Women, you recognize an obligation to promptly remit payment to Tidewater Physicians for Women.

___ 4. We advise that you familiarize yourself with the benefits of your insurance plan. Certain health insurances require that you obtain a referral or prior authorization from your Primary Care Physician before visiting a specialist. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower or no payment from the insurance company, and the balance will be your responsibility. Alternative payment arrangements or rescheduling of your appointment may be necessary if not obtained.

___ 5. I understand and agree that if I fail to make any of the payments for which I am responsible for in a timely manner, after such default and upon referral to a collection agency or attorney by Tidewater Physicians for Women, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.

___ 6. Labs that are offered in our practice can be expensive and should be discussed with your provider before having them sent to a lab. Screening labs are often not a covered service. I understand if the cost is a concern, a price list can be referred to in our lab area.

___ 7. I understand I am responsible for any charges not covered by my insurance, including but not limited to co-payments, deductibles, and non-covered services. An estimate of benefits may be provided to me by this office upon request but is not a guarantee of payment. My insurance company will make the final determination of my claim(s) once the claim(s) are received and processed under the terms of my contract and with my insurance company or third party payer. It is my responsibility to understand the conditions, limitations, and benefits of my policy before obtaining any service, and I will be financially responsible for any unmet deductibles, coinsurance, copays, or non-covered services at the time of service. Any additional unanticipated balances will be due after my claim is filed, and all balances will be due within 60 days of having the services rendered.

At Tidewater Physicians for Women, we understand that financial problems may affect timely payment, so we encourage you to communicate any such issues with us so that we may assist you in keeping your account in good standing. If you have any questions, please call our Billing Department at (757) 461-4710 or (757)461-3890.

I UNDERSTAND THE ABOVE INFORMATION AND WILL BE RESPONSIBLE FOR THE PATIENT LISTED BELOW

Printed Name of Patient: _____Account #:_____

Signature of Responsible Party Date

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Definition of a Routine Well-Woman Visit

The focus of a well-woman visit is preventative care. If tests or services beyond the scope of a well-woman visit are provided, then additional charges may be incurred for those services. The choice to address both well care and medical issues is offered for the convenience of avoiding two visits; however, you may owe a cost share/copay for this additional service. Although our office will assist you with your insurance processing, it is the patient's responsibility to understand their insurance benefits.

What is included in a Well-Women Visit?	
Yes	**No**
A review of your current health and medical history.	Treatment or consultation for a specific medical condition.
Counseling about ways to improve your health.	Any service not considered part of a Well-Woman visit.
A physician exam tailored to your preventative care needs.	Any services that are not part of a routine Well-Woman Visit.
Immunizations and screening tests, if needed (Some insurances will not cover these tests).	Additional tests or services that are not part of a routine Well-Woman Visit.

Your scheduled appointment today is for a well-woman visit. Each insurance company has different contracts regarding group and individual coverage for Well Exam benefits. If tests or services beyond the scope of a well-woman visit are provided, then you may incur additional charges that are required to be paid at check out, if not collected at check-in.

If you are uncertain of your coverage, please contact your insurance company regarding benefits.

_____
Signature of Patient/ Parent/ Guardian

_____
Date

Name: **Tidewater Physicians for Women**
SSN: DOB: **Patient Medical History Questionnaire**

Preferences:
Primary Care Physician: _____
Patient Pharmacy:_____Location/Phone # _____

Drug Allergies and Adverse Reaction:
_____

Medications Including Vitamins and Herbs (list name dose and frequency):
1._____ 4. _____ 3. _____
2._____ 5. _____ 8. _____
3. _____ 6. _____ 9. _____

Gynecologic History: (mark all that apply)
Menstrual history: Duration of flow (days)_____Frequency of cycle_____Age at first period _____
Date of last: Mammogram_____Colonoscopy _____ Pap Smear _____
Abnormal Pap/dysplasia: □ treatments and date_____

Recent birth control:
□ Birth control pills □ Depo-provera □ Nuvaring □ Condoms □ Tubal ligation □ Vasectomy □ Abstinence
□ Mirena IUD_____□ Paragard IUD_____□ Kyleena IUD_____□ Nexplanon ___□ Essure _____

Ever been diagnosed with □ Genital herpes □ Gonorrhea □ Chlamydia □ Pelvic inflammatory disease □ HIV
□ HPV/genital warts □ Syphilis □ Endometriosis □ Infertility □ Fibroids

Pregnancies:
Total pregnancies:_____Full term deliveries:_____Premature deliveries:_____Miscarriage:_____ Abortions:_____
Ectopic:_____Living:_____

Date /Weeks at delivery/ Length of labor/ Birth weight/ Vaginal,Vacuum,C-section/ Gender/ Place of delivery/ Comments
1._____
2._____
3._____
4._____
5._____

Family History (indicate which relative and maternal/paternal side and age at diagnosis):
□ No breast, gynecologic, colon cancer or malignant melanoma
□ Breast cancer
□ Colon cancer
□ Ovarian cancer
□ Other:_____
Uterine/endometrial cancer
□ Malignant melanoma
□ Pancreatic Cancer

Name:
SSN: DOB:

Tidewater Physicians for Women
Patient Medical History Questionnaire

Social History:

Smoking Status: □ Never Smoked □ Former smoker, quit when _____□ Current Smoker: How many a day?_____
Use of: □ Smokeless tobacco □ Electronic Cigarettes or Vape

Have you ever been sexually active? □ No □ Yes: Age at first sexual intercourse____Number of lifetime partners_____
Number of current sexual partners _____Protected sex?_____Oral sex? _____
Partner preference: □ Male □ Female □ Both

Occupation/employer_____
Education History _____ Religion _____
Do you drink alcohol? Amount and frequency_____Have you had problems with alcohol? □ Yes □ No
Do you currently use or used in the past street drugs: □ Marijuana □ Cocaine □ Heroin □ Narcotic dependence
□ Methamphetamines □ Hallucinogens □ Other_____
□ Have you been treated for a drug or alcohol problem in the past? □ No □ Yes
□ Do you have an Advanced Directive? □ No □ Yes Ashkenasi Jewish Descent □ No □ Yes

Have you experienced: □ Domestic abuse □ Physical abuse □ Sexual abuse □ None

Surgical History: Mark all that apply and date surgery performed: **□ I have not had any surgeries**

□ Abdominoplasty_____
□ Appendectomy_____
□ Bariatric (gastric bypass)_____
□ Cholecystectomy (gallbladder)_____
□ Multiple abdominal surgeries_____
□ Dilatation & curettage (D&C)_____
□ Ectopic pregnancy_____
□ Endometrial ablation_____
□ Hysteroscopy_____
□ Laparoscopy for_____
□ Laparotomy (abdominal exploration)_____
□ Hysterectomy by:
□ Laparoscopic removal of uterus without removal of cervix _____
□ Laparoscopic removal of uterus and cervix _____
□ Abdominal removal of uterus without removal of cervix _____
□ Abdominal removal of uterus and cervix _____
□ Vaginal hysterectomy _____
□ Cesarean section (s) _____
□ Other: _____

□ Breast biopsy_____
□ Breast implants_____
□ Lump removed from breast_____
□ Mastectomy_____
□ Thyroid surgery_____
□ LEEP/cone biopsy_____
□ Myomectomy_____
□ Ovary removal: □ Both___□ Left___□ Right___
□ Ovarian cyst removed_____
□ Tubal ligation_____
□ Tube removal: □ Both___□ Left___□ Right_____

Past or Current Medical History (conditions are currently or have been treated):

□ None
□ Anemia
□ Anesthesia complication
□ Anxiety disorder
□ Asthma
□ Birth defects/inherited diseases
□ Blood clot in your vein or lungs
□ Breast cancer
□ Colon cancer
□ Depression
□ Diabetes
□ High cholesterol
□ Gastrointestinal problems
□ Headaches or migraines
□ Other:_____
_____

□ Heart condition
□ Heart disease
□ Hepatitis
□ High blood pressure
□ Kidney disease
□ Kidney or bladder problems
□ Osteopenia
□ Osteoporosis
□ Ovarian cancer
□ Other cancer
□ Psychiatric illness
□ Pancreatic Cancer
□ Thyroid problems
Vitamin D deficiency