Women's Cancer &Wellness Institute

Randal J. West, MD Diane Cox, MD Ruth Felsen, MD
1401 Johnston Willis Drive, Suite 1100, North Chesterfield, VA 23235
9101 Stony Pont Drive, Suite 3300, Richmond, VA 23235

Patient Registration Form

Patient's name: _____ Social Security #: _____

Date of birth: _____ Primary phone #: _____ Secondary phone #: _____

☐ Male ☐ Female Email address: (print clearly) _____

Ethnicity: ☐Hispanic/Latino ☐Not Hispanic/Latino ☐Declined ☐ Other: _____

Race: ☐Caucasian ☐African American ☐Asian ☐ Hispanic ☐ Declined ☐ Other: _____

Mailing address: _____

City, State: _____ Zip: _____

Patient's employer: _____ Work phone #: _____

☐ I have no insurance, I am self-insured

Primary Insurance: _____ Policy Number: _____

Group Number: _____ Policy Holder Name: _____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Child

Secondary Insurance: _____ Policy Number: _____

Group Number: _____ Policy Holder Name: _____

Emergency contact name: _____ Phone number w/area code: _____

Relationship to patient: _____ DOB: _____

Preferred Pharmacy: _____ Phone Number: _____

Primary Care Doctor: _____ Phone #: _____

By signing this form below, I authorize all services be billed to my insurance company for payment and for all benefits to be paid directly to Women's Cancer and Wellness Institute. I understand and agree if my account, or the account of the individual I am guaranteeing, is placed with a collection agency and/or attorney for collection, I agree to pay the balance owed in addition to any and all costs of collection, including within limitation, an attorney fee equal to one-third (1/3) of outstanding balance and all other costs associated with collection. If you fail to give us all active insurance policies, then you may be responsible for any charges denied for timely filing. I understand there is a $50 returned check fee.

_____ _____

Patient Signature Date

_____ _____

Legal Guardian Date

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Financial Policy

• Your copayment (copay) is due at check-in. The copayment is a fixed fee defined in your insurance policy that is paid each time a medical service is accessed. Most copayment amounts should be listed on your insurance card. Please be prepared to pay the copayment at check-in to avoid being rescheduled.

• If you do not have insurance, there will be a $280 prepayment due towards the charge for services prior to being seen. You will also be required to sign a payment plan before being seen.

• Please note that any procedures, lab work, etc., that you have done outside of this office or that is sent for interpretation, is not included in your office visit(s). You will receive a separate invoice for these charges directly from the facility providing the service.

• If you have an outstanding balance with us and you have not arranged a payment plan, then you will be required to make a payment on the balance and sign a payment plan for a monthly amount.

• Payment plans are available for patients needing to make special arrangements to pay off their bills. These arrangements should be made in advance of receiving services. If you are placed on a payment plan and default this payment, then your account will be sent to collections.

• Please feel free to ask questions and discuss financial matters with our financial staff in the business office.

• For your convenience, we accept Visa, Mastercard, American Express, Debit Cards, Cash, personal check and money orders. We do not accept CareCredit.

• If you do not show for an appointment that you confirmed, you may be charged a $75 no show fee, which must be paid before your next visit. We reserve the right to dismiss any patient from the practice after three consecutive no show appointments.

• **For Johnston Willis Office Patients only:** If you are scheduled for surgery and cancel less than 10 days prior to your surgery date, then you will be charged $300. *If this surgery was for a mastectomy, then this charge will be $600.*

• For BOTH offices: If you are scheduled for surgery and have a remaining balance on your deductible, we will collect the remaining balance or $500 maximum. You will be billed for the remaining balance once your insurance processes your claim.

• A $50 return check fee will be charged for all returned checks.

• We charge $30 to complete forms, $.50 per page for medical records along with a $20 processing fee. This payment is due PRIOR to completion. Insurance does not cover these charges.

• We participate with many insurance companies. If your insurance company is one in which we do not participate, you are responsible for payment of your account.

• Parents and guardians of minor children will be held fully responsible for the account unless notified with appropriate documentation.

• You, the patient, hereby authorize Women's Cancer and Wellness Institute to release any information necessary to complete and process your insurance claims.

Printed Name: _____ Date: _____

Signature: _____ Date: _____

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HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Patient Name: _____

Date of Birth: _____/_____/_____ Social Security Number: _____-_____-_____

Please list name(s) of individual(s) who are privileged to your personal health information:

Name _____ Relationship_____
Name _____ Relationship_____
Name _____ Relationship_____
Name _____ Relationship_____

***Note: If an individual is not listed, we cannot speak to them about your health care. ***

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party. I understand that uses and disclosures already made based upon my original permission cannot be taken back. I understand that it is possible that information used or disclosed with my permission may be redisclosed by the recipient and is no longer protected by the HIPAA Privacy Standards. I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization. I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

_____ _____

Signature of Patient Date

Patient Name: _____ **DOB:** ____/____/____

Age _____ SSN _____ (Used to Access Hospital Records Only)

Primary Care Physician _____

Ph: _____ Fax: _____

Who referred you today _____

Ph: _____ Fax: _____

Reason for Visit_____

Other Physicians that you see_____

Pharmacy Name & Number _____

Medications (include prescription and over the counter)

Medication	Dosage	Reason

Allergies _____

Past Medical History (Circle if you have/had)

Heart problems / Stroke / Blood Clot / Asthma / Cancer: _____

High Blood Pressure / Diabetes / Arthritis / COPD / Osteoporosis/Other_____

Gynecologic History

Pregnancies _____ Miscarriages _____ Abortions _____ # of living children_____

Year of last Mammogram_____ Age at First Baby_____ Age at First Period_____

Date of Last Pap_____ History of Breast Feeding_____ Colonoscopy/Year _____

History of Birth Control_____ History of Hormone Replacement Therapy_____

List of Surgeries/Hospitalizations with dates & physicians (if known)

_____

_____

_____

Social History

Occupation (if retired, previous occupation) _____

Marital Status: (circle) Single Married Widowed Divorced Separated

Cigarette Use: Nonsmoker / Smoker / Packs per day _____/ # of year's ____/ Prior smoker

Alcohol Use # of drinks: weekly / monthly _____ Recreational Drug Use: Yes / No

Patient Name: _____ DOB: ____/____/____

Review of Symptoms (Please circle all that apply):

General	Fever	Poor Appetite	Weight Loss	Weight Gain	Fatigue	None	
Eyes	Glasses	Contacts	Blurry Vision	Double vision	Pain	None	
Ear/Nose/ Throat	Sore Throat	Mouth Sores	Sinus Problems	Nose Bleeds	Ear Infection	None	
Respiratory	Cough	Wheezing	Asthma	Trouble Breathing	Shortness of breath	none	
Cardiovascular	Palpitations	Chest Pain	High Blood Pressure	Heart Attack	Bypass/ Stents	Stroke	None
Blood/Lymph	Swollen Glands	Bleeds Easily	Abnormal Blood Clotting	Blood Clot	None		
Breasts	Lumps	Pain	Nipple Discharge	Cancer	None		
Gastrointestinal	Nausea	Heartburn/ Pain	Blood in Stool	Abdominal Swelling	Constipation	Diarrhea	None
Urinary	Leak Urine	Painful Urination	Frequent Urination	Blood in Urine	None		
Reproductive	Vaginal Bleeding	Vaginal Discharge	Irregular Periods	Pain	Bleeding after sex	Fibroids	None
Musculoskeletal	Leg Swelling	Joint Pain	Neck Pain	Back Pain	Swollen joints	None	
Skin	Rash	Itching	Lumps	None			
Endocrine	Unusual thirst	Heat Intolerant	Cold Intolerant	Hot Flashes	Irregular periods	none	
Neuro/Psych	Tremors	Dizziness	Numbness	Sadness	Anxiety	None	

Family History (Please Check):

	Mother	Father	Sibling	Children	Aunts/Uncles/Grandparents
Breast Cancer					
Uterine Cancer					
Ovarian Cancer					
Colorectal Cancer					
Pancreatic Cancer					
Prostate Cancer					
High Blood Pressure					
Diabetes					
Stroke					
Heart Problems					
Blood Clots					
Other					

Additional Information: _____

_____

_____

_____