

Patient Name: _____ DOB: ___/___/___ Today's Date: ___/___/___

About your daughter... (for parents/caregivers only)

What about her makes you proud? _____

What seems to be the greatest challenge for her? _____

Anything else you would like us to know? _____

What is the main reason for the appointment today? _____

Please understand that most insurance companies do not pay for care of problems and preventive / wellness care provided on the same day. The patient is responsible for additional fees if this applies. Please let us know if you would like to schedule a separate appointment on a different day to better meet your needs.

Annual Exam (well-check) _____

Physical Symptoms _____

Nutrition, Body Image _____

Social, Emotional, Mood Concerns _____

Risk Behaviors, Safety _____

Sexuality, Gynecology _____

Medication questions, refills needed _____

For New Patients Only

Previous primary care physician(s) _____

Purpose of appointment is to establish ongoing primary care consult about a problem

How did you hear about us? Physician: _____ GTW Patient Community Friend Program Internet

Treatment Team

On-going Primary Care Provider: GTW Other: _____

Medical Specialists _____

Psychiatrist _____

Counselor/Therapists _____

Mental Health or Educational Testing _____

Other _____



Patient Medical History If established patient, note any NEW info or NO CHANGES _____				
Allergy/Asthma/Imm <input type="checkbox"/> asthma <input type="checkbox"/> seasonal allergies <input type="checkbox"/> food allergies <input type="checkbox"/> frequent infections <input type="checkbox"/> immune deficiency	Dermatology <input type="checkbox"/> acne <input type="checkbox"/> eczema <input type="checkbox"/> psoriasis <input type="checkbox"/> cancerous moles or melanoma	Gastroenterology <input type="checkbox"/> irritable bowel syndrome <input type="checkbox"/> reflux or GERD <input type="checkbox"/> chronic constipation <input type="checkbox"/> Crohn's or ulcerative colitis <input type="checkbox"/> celiac disease	Endocrine <input type="checkbox"/> thyroid disorder <input type="checkbox"/> diabetes type 1, insulin dependent <input type="checkbox"/> diabetes type 2, non-insulin dependent <input type="checkbox"/> PCOS	Infectious Disease <input type="checkbox"/> chicken pox <input type="checkbox"/> mononucleosis <input type="checkbox"/> pneumonia
Cardiovascular <input type="checkbox"/> heart murmur <input type="checkbox"/> heart problems <input type="checkbox"/> fainting or dizziness with exercise <input type="checkbox"/> abnormal heart rhythm <input type="checkbox"/> blood clot <input type="checkbox"/> high cholesterol <input type="checkbox"/> high blood pressure	Orthopedic <input type="checkbox"/> broken bones <input type="checkbox"/> arthritis <input type="checkbox"/> scoliosis	GYN/Urology <input type="checkbox"/> urinary tract infection <input type="checkbox"/> kidney problems <input type="checkbox"/> severe menstrual cramps <input type="checkbox"/> ovarian cyst(s) <input type="checkbox"/> sexually transmitted infection <input type="checkbox"/> pregnancy	Neurodevelopmental <input type="checkbox"/> birth complications <input type="checkbox"/> developmental delay <input type="checkbox"/> genetic disorder <input type="checkbox"/> speech or language delay <input type="checkbox"/> learning disorder <input type="checkbox"/> autism <input type="checkbox"/> Asperger's <input type="checkbox"/> ADD/ADHD	Neuropsychology <input type="checkbox"/> migraines <input type="checkbox"/> tics <input type="checkbox"/> seizures <input type="checkbox"/> depression <input type="checkbox"/> anxiety <input type="checkbox"/> eating disorder <input type="checkbox"/> drug use <input type="checkbox"/> tobacco use

Patient Medical History If established patient, note any NEW info or NO CHANGES _____

Recent Exams/Labs _____ Approx Date: ___/___/___
 Major Injuries _____ Approx Date: ___/___/___
 Surgeries _____ Approx Date: ___/___/___
 Hospitalizations _____ Approx Date: ___/___/___
 Immunization Status Up to Date Not sure

Family Life If established patient, note any NEW info or NO CHANGES _____			
Who does patient live with most of the time?	Occupation (if applies)	Part-time	Full-time
<input type="checkbox"/> Mother		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Father		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Step-Mother		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Step-Father		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Brother(s)	Ages: _____		
<input type="checkbox"/> Sister(s)	Ages: _____		
<input type="checkbox"/> Other:			

If patient lives in more than one home, what are the custodial arrangements? _____

FAMILY MEDICAL HISTORY If established patient, note any NEW info or NO CHANGES _____				
Mother	Father	Siblings	Grandparents	Other (explain)
<input type="checkbox"/> Asthma	<input type="checkbox"/> Asthma	<input type="checkbox"/> Asthma	<input type="checkbox"/> Asthma	<input type="checkbox"/> Asthma
<input type="checkbox"/> Bleeding or clotting disorders	<input type="checkbox"/> Bleeding or clotting disorders	<input type="checkbox"/> Bleeding or clotting disorders	<input type="checkbox"/> Bleeding or clotting disorders	<input type="checkbox"/> Bleeding or clotting disorders
<input type="checkbox"/> Blood disorders or sickle cell anemia	<input type="checkbox"/> Blood disorders or sickle cell anemia	<input type="checkbox"/> Blood disorders or sickle cell anemia	<input type="checkbox"/> Blood disorders or sickle cell anemia	<input type="checkbox"/> Blood disorders or sickle cell anemia
<input type="checkbox"/> Heart attack/stroke	<input type="checkbox"/> Heart attack/stroke	<input type="checkbox"/> Heart attack/stroke	<input type="checkbox"/> Heart attack/stroke	<input type="checkbox"/> Heart attack/stroke
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> High blood pressure
<input type="checkbox"/> High cholesterol	<input type="checkbox"/> High cholesterol	<input type="checkbox"/> High cholesterol	<input type="checkbox"/> High cholesterol	<input type="checkbox"/> High cholesterol
<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Kidney disease
<input type="checkbox"/> PCOS	<input type="checkbox"/> Migraine headaches	<input type="checkbox"/> PCOS	<input type="checkbox"/> PCOS	<input type="checkbox"/> PCOS
<input type="checkbox"/> Migraine headaches	<input type="checkbox"/> Obesity	<input type="checkbox"/> Migraine headaches	<input type="checkbox"/> Migraine headaches	<input type="checkbox"/> Migraine headaches
<input type="checkbox"/> Obesity	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Obesity	<input type="checkbox"/> Obesity	<input type="checkbox"/> Obesity
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Cancer (type)	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Cancer (type)	(_____)	<input type="checkbox"/> Cancer (type)	<input type="checkbox"/> Cancer (type)	<input type="checkbox"/> Cancer (type)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

FAMILY MENTAL HEALTH History If established patient, note any NEW info or NO CHANGES _____				
Mother	Father	Siblings	Grandparents	Other (explain)
<input type="checkbox"/> Depression	<input type="checkbox"/> Depression	<input type="checkbox"/> Depression	<input type="checkbox"/> Depression	<input type="checkbox"/> Depression
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Learning disability	<input type="checkbox"/> Learning disability	<input type="checkbox"/> Learning disability	<input type="checkbox"/> Learning disability	<input type="checkbox"/> Learning disability
<input type="checkbox"/> OCD	<input type="checkbox"/> OCD	<input type="checkbox"/> OCD	<input type="checkbox"/> OCD	<input type="checkbox"/> OCD
<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> ADD/ADHD
<input type="checkbox"/> Suicide	<input type="checkbox"/> Suicide	<input type="checkbox"/> Suicide	<input type="checkbox"/> Suicide	<input type="checkbox"/> Suicide
<input type="checkbox"/> Bipolar	<input type="checkbox"/> Bipolar	<input type="checkbox"/> Bipolar	<input type="checkbox"/> Bipolar	<input type="checkbox"/> Bipolar
<input type="checkbox"/> Schizophrenia	<input type="checkbox"/> Schizophrenia	<input type="checkbox"/> Schizophrenia	<input type="checkbox"/> Schizophrenia	<input type="checkbox"/> Schizophrenia
<input type="checkbox"/> Alcohol/drug abuse	<input type="checkbox"/> Alcohol/drug abuse	<input type="checkbox"/> Alcohol/drug abuse	<input type="checkbox"/> Alcohol/drug abuse	<input type="checkbox"/> Alcohol/drug abuse
<input type="checkbox"/> Eating disorder	<input type="checkbox"/> Eating disorder	<input type="checkbox"/> Eating disorder	<input type="checkbox"/> Eating disorder	<input type="checkbox"/> Eating disorder
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Stressors/Changes or NO significant stressors/changes _____

- New School
- Recent move
- Deployed parent
- Family financial or legal problems
- Parental job loss
- Parental conflict or divorce
- Illness/death in family
- Death of friend

Who is completing this form? Patient Mother Father Other: _____





Financial Policies and Advance Beneficiary Notice Regarding Covered vs. Non-covered Services

Insurance. It is the responsibility of the guarantor and/or parent on the account to know his/her insurance plan. If you are unsure what your insurance will cover at any given office visit, please contact your insurance company for benefit and payment information.

- **In-Network Services** We have made prior arrangements with many insurers/health plans to accept assignment of benefits. We will bill these plans and require you to pay the authorized patient portion at the time of service.
- **Out-of-Network Services** If you have insurance coverage with a plan for which we do not have a prior agreement, we will prepare a receipt for **you** to submit to your insurance. This means that your insurer will send the payment directly to you. Consequently, the charges for your care and treatment are due at the time of service.
- **Girls to Women will only file insurance claims to ONE primary insurance company.** We will provide you with a claim you can submit directly to your Secondary Insurance Provider. Your account will reflect the balance after your primary has paid.

Co-pays, deductibles, and outstanding balances are due and payable at the time of service. The guarantor and/or parent on the account is responsible for balances not covered/paid by your insurance plan. Any account that becomes delinquent may be subject to additional charges. For all services rendered to minor patients, the adult accompanying patient will be responsible for payment. For patients not filing insurance or for predetermined non-covered services, full payment is due at the time of service unless other arrangements have been made in advance.

Telephone/Email Fees. There is a charge for telephone/email treatment that avoids an office visit (during or after office hours). These services are typically not covered by insurance plans. Guarantor and/or parent on the account is responsible for payment.

School/Camp forms, disability forms, letters to insurance companies, copies of medical records, etc., Upon request, GTW physicians will complete standard annual physical forms at the time of a scheduled annual physical/wellness exam without additional charge. Thank you for understanding that completing forms or other correspondence outside of scheduled annual visits requires staff and physician time; a fee will be charged for this service.

Cancelled/Missed Appointments. Missed appointments and appointments not cancelled 24 business-hours in advance of the scheduled time will be charged \$60. Guarantor/parent on the account is responsible for payment.

Credit Cards. As a convenience to our patients, we accept VISA, MasterCard, American Express, and Discover.

ADVANCE BENEFICIARY NOTICE regarding COVERED VS. NON-COVERED SERVICES. Health insurers do not necessarily pay for all of your health care costs. Insurance only pays for covered items and services. Coverage varies by diagnosis, service provided, and terms of benefits arranged by individual or employee sponsors of each plan. The fact that insurance may not pay for a particular service does not mean that you should not receive it, if your doctor recommends that you do receive this service; it is always your choice. The purpose of this notice is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. In the event that insurance denies payment for a non-covered diagnosis or a non-covered service, the patient will be responsible for full payment, due upon receipt of a statement from our office. By signing below you agree to take financial responsibility for the cost of the item(s) or service(s), if your health insurance does not include this as a covered item(s) or service(s). We may require a credit card number on file to charge for services deemed not covered by your insurance. Your health insurance may not pay for the item(s) or service(s) described below:

- Missed appointments / no shows
- Medical assessment or advice provided by telephone or email by nurse or physician
- Routine Annual Physicals or other Preventive Health services
- Extended time (physician office visit greater than 1 hr, each additional 30-60 min)
- Completion of documents, letters or forms
- Review of records, coordination of care between specialists
- Parent/Family consultation when patient not present
- Medical nutrition therapy provided by physicians, nurses, or licensed dietitians
- Mental health counseling services provided by physicians, nurses, or licensed therapists
- Immunizations
- Group appointments or classes
- Books, CD/DVDs, educational materials, fitness equipment, medical products

I have read, understand, and agree to the financial policy of this practice, and I agree to be bound by its terms. I also understand and agree that the practice may amend such terms from time to time. I understand that charges not covered by my insurance company, as well as applicable copayments and deductibles, are my responsibility and are due at time of service.

_____	_____	____/____/____
Patient Name (print)	Patient Signature (adult patients only)	Date

_____	_____	____/____/____
Responsible Party (print) (if patient is a minor)	Responsible Party Signature (if patient is a minor)	Date



Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Girls to Women Health and Wellness, PA to use and disclose protected health information (PHI) about me (or my minor child) to carry out treatment, payment and health care operations (TPO). The Notice of Privacy Practices provided by Girls to Women Health and Wellness, PA describes such uses and disclosures more completely. I have the right to review the Notice of Privacy Practices prior to signing this consent. Girls to Women Health and Wellness, PA reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the privacy officer for Girls to Women Health and Wellness, PA.

With this consent, Girls to Women Health and Wellness, PA may:

- **call my home phone, mobile phone and/or other prior designated alternative location and leave a message on voice mail or in person** in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.
- **mail to my home, e-mail and/or other prior designated alternative location** any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I have the right to request that Girls to Women Health and Wellness, PA restrict how it uses or discloses my (or my minor child's) PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to allow Girls to Women Health and Wellness, PA to use and disclose my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, in writing, Girls to Women Health and Wellness may decline to provide treatment to me (or my minor child).

_____	_____	____/____/____
Patient Name (print)	Patient Signature (adult patients only)	Date

_____	_____	____/____/____
Parent / Guardian (print) (if patient is a minor)	Parent / Guardian Signature (if patient is a minor)	Date

Authorization for Release of Information to Insurance and Assignment of Insurance Benefits

I hereby authorize release of information to my insurance company on file and assignment of insurance benefits to Girls to Women Health and Wellness, PA, Drs. Rubin-Remer, Sugerman, and Musacchio, as this information may be necessary for the completion of my medical claims. I understand I am financially responsible for all charges not covered by my insurance company.

_____	_____	____/____/____
Patient Name (print)	Patient Signature (adult patients only)	Date

_____	_____	____/____/____
Responsible Party (print) (if patient is a minor)	Responsible Party Signature (if patient is a minor)	Date



ONLY For Adult Patients (18 years of age or older)

RELEASE OF INFORMATION TO PARENT/GUARDIAN

I, _____, authorize Girls to Women Health and Wellness to discuss/release the following
Patient Name (print)

protected health information to my parent(s)/guardian, named below, whether by phone, email or regular mail, as follows: (please check one only)

- Any and all protected health information (this may include sexual health, mental health, alcohol/drugs and HIV/AIDS information)
Any and all protected health information (this may include mental health)
Sexual Health and HIV/AIDS information
Alcohol and Drugs
ONLY Specific medical condition(s) (please state):

I authorize this information to be released to: _____ and/or _____
Print name of parent/guardian Print name of parent/guardian

This authorization is to be in effect until such time as I revoke it in writing.

_____/_____/_____
Patient Name (print) (adult patients only) Patient Signature (adult patients only) Date