VIRGINIA WOMEN'S HEALTH ASSOCIATES
INTERIM HISTORY

PATIENT NAME: ______________________ **ACCT#:** ____________

Reason for visit: Annual Follow up Problem visit

Do you have any questions or concerns for the doctor?

1.____

****Please note that all of your concerns may not be addressed at today's visit. You may have to schedule another appointment to adequately address additional concerns.****

Are you currently trying to conceive? ☐Yes ☐ No First day of last period________________

If not, what method of family planning are you using?______________________________

New allergies: ☐ No

☐ Yes To what?_____________ Reaction?____________________ ____

Any change in medication?____

Any surgery since last visit?____

Any new family history?____

Are your currently being evaluated for any medical problems by another physician?____________

____

Have there been any changes in:

☐ Marital Status ☐ Occupation ☐ Exercise ☐ Tobacco ☐ Alcohol

When was your last:

Pap smear_________ Mammogram___________ DEXA Scan__________ Colonoscopy___________

Will you need a prescription refill today?

☐ Contraception ☐ Hormone Replacement Therapy ☐ Osteoporosis medication ☐ Valtrex/Famvir

Other____________________________

According to the American College of Obstetrics and Gynecology it is recommended that patients, **age 25 or less**, be tested for Chlamydia/Gonorrhea. In addition, we recommend regular testing for other sexually transmitted diseases (STD's) if indicated.

Please indicate your preference:

_____I wish to be tested for Chlamydia/Gonorrhea today.

_____I decline to be tested for Chlamydia/Gonorrhea today.

_____I wish to be tested for STD's today.

_____I decline to be tested STD's today.

*******Please note that your insurance company may not pay for STD testing*******

PROVIDER USE ONLY:

Vitals: BP_____________Weight_____________Height________________BMI___________________

<u>Patient Communication Preferences, HIPAA Privacy Rule, & Consent</u>

In a continued effort to better serve our patients, we have developed a new communications process and ask that you indicate your preferences below. These preferences will be used for automated *appointment confirmations, normal lab result notifications, health maintenance reminders, inclement weather alerts, and other notifications.*

Please select only **ONE** option

↙ **or** ↘

☐ Please **TEXT MESSAGE** me with all notifications.
Preferred Phone Number: ___________________

☐ Please **CALL** me with all notifications.
Preferred Phone Number: ____________________

NOTE**:** The HIPAA Privacy Rule permits providers to communicate with patients regarding their health care via mail and phone. Additionally, the HIPAA Privacy Rule <u>allows providers to leave messages for patients on their answering machines regarding their healthcare</u>. If you do **NOT** wish to receive any voice messages with private health information, please indicate that below.

☐ **I DO NOT** want VWHA to leave voice messages – affiliated with the phone number(s) I have provided the practice – with private health information, to include lab results.

Email Address: ____

(To be used with Patient Portal - **coming soon**)

As the patient, I am in understanding that should my telephone number(s) change, it is my responsibility to update contact information with my doctor's office (VWHA).

Patient Signature: _________________________________

Patient Printed Name: _________________________________

Date: _________________________________

Camilla C. Hersh, M.D. **Stephanie Swanson, M.D.**
Amy B. Rembold, PA-C **Chana-Rivka Foster, M.D.**

PERSONAL HEALTH INFORMATION AUTHORIZATION FORM

Patient Name: ____ DOB: ____________________

I, ________________________________, give permission to Virginia Women's Health Associates (VWHA) to use or disclose my personal health information to the following person(s):

Name: ____

Relationship to Patient: ____

☐ __________________________________By signing here, I authorize *ANY AND/OR ALL* of my personal health information to be shared with the individual(s) listed above.

☐ __________________________________By signing here, I authorize my personal health information to be shared with the individual(s) listed above *with the following LIMITATIONS AND/OR SPECIAL INSTRUCTIONS*:____
____

By signing below, I certify that I have read and understand authorization to Virginia Women's Health staff to share all/limited personal health information to the above individual(s). Furthermore, I understand that I may revoke this authorization at any time by asking to complete a revocation form that VWHA will provide me upon request. I understand that such revocation will become effective on the date I complete the request form and will have no effect on the uses and/or disclosures made prior to that date. THIS AUTHORIZATION WILL EXPIRE ONLY AFTER I COMPLETE A REVOCATION FORM

1800 Town Center Drive | Suite 220 | Reston, VA 20190
Office: 703-435-2555 | Fax: 571-926-8894

I acknowledge that I have had an opportunity to read and understand the contents of this authorization form and my signature confirms that this authorization form accurately reflects my wishes.

Patient Signature: _______________________________ Date: _____________________________

Preventative Medical Visit – Patient Information & Consent

A preventative medical visit, more commonly known as an "annual exam", is a comprehensive preventative medical evaluation and management of care, to include an age and gender appropriate history, examination, anticipatory guidance and counseling, risk factor reduction interventions, and the ordering of routine laboratory and/or diagnostic procedures.

Insurance carriers may or may not provide coverage for preventative services. Furthermore, coverage and payment for preventative services vary from carrier to carrier, and most insurance plans ***do not*** require a copayment for this type of visit.

However, if an abnormality is encountered or a preexisting problem is addressed in the process of performing your annual exam, and/or the problem encountered is significant enough to require additional work to perform key components of a problem-oriented evaluation, then a separate office visit code may be charged. The use of this additional code may require a copayment, due at the time of service, if one is charged by your insurance plan.

By signing below, I certify that I have read and understand the differences between preventative and problem-oriented visits, and agree to pay the associated copayment should the nature of my visit change.

Patient Signature: _______________________________

Patient Printed Name: _______________________________

Date: _______________________________