## RESTON WOMEN’S CENTER

## 1850 TOWN CENTER PKWY, SUITE 650, PAVILION II, RESTON, VA 20190

## 703-955-5978│703-830-4188 (f)

## CENTREVILLE OB/GYN

## 14701 LEE HWY, SUITE 304

## CENTREVILLE, VA 20121

## 703-830-4388│703-830-4188 (f)

|  |
| --- |
| ***PATIENT INFORMATION*** |

Name (Last) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (First) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (M.I.) \_\_\_\_\_\_\_

Preferred Name: \_\_\_\_\_­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_

Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Social Security #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

State \_\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Race \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ethnicity \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred Language\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email to sign up for Patient Portal\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| Appointment reminders: Do you prefer **[ ] Phone call [ ] Text Message [ ] none** |

***Insurance Information***

Who is the insured? [ ] Self [ ] Spouse [ ] Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you are **NOT** the policy holder, please complete the following:

Name (of the insured):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB (of the insured):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber ID:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address (of the insured, if different from yours):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If insurance is Tricare** please provide the policy holder’s Social Security#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***PREFERRED PHARMACY INFORMATION***

Pharmacy Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City/State/Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## CENTREVILLE OB/GYN

## 14701 LEE HWY, SUITE 304

## CENTREVILLE, VA 20121

## 703-830-4388│703-830-4188 (f)

## RESTON WOMEN’S CENTER

## 1850 TOWN CENTER PKWY, SUITE 650, PAVILION II, RESTON, VA 20190

## 703-955-5978│703-830-4188 (f)

**For medical staff use: Height:\_\_\_\_\_\_\_\_ Weight:\_\_\_\_\_\_\_\_\_\_\_\_\_ B/P:\_\_\_\_\_\_\_\_\_\_\_\_\_HR:\_\_\_\_\_**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for your visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Medication** \*including vitamins and minerals\*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Drug Name** | **Dose** | | **Drug Name** | **Dose** |
|  |  |  | |  |
|  |  |  | |  |
|  |  |  | |  |
|  |  |  | |  |
|  |  |  | |  |

***General Medical History***

Please circle any conditions you have or have had before:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |
| Alcoholism | | Gastric Ulcer | | Migraine | |
| Anemia | | GERD | | MTHFR | |
| Anxiety | | Gestational Diabetes | | Obesity | |
| Arthritis | | Glaucoma | | Pneumonia | |
| Asthma | | Headache | | Pulmonary Disease | |
| Blood Transfusion | | Heart Attack | | Reflux | |
| Broken Bones | | Heart Murmur | | Rheumatic Fever | |
| Cancer | | Hepatitis | | Rheumatoid Arthritis | |
| Chickenpox | | High Cholesterol | | Stroke | |
| CVA | | High Risk Pregnancies | | Thyroid Disease | |
| Depression | | HIV or AIDS | | TIA | |
| Diabetes | | Hypertension | | Tuberculosis | |
| Eating Disorder | | Hypothyroidism | | Urinary Tract Infections | |
| Epilepsy | | Kidney Infections | | STD’s | |
| Gallbladder Disease Kidney Stone | | | Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |

**Patient Name: DOB:**

***ALLERGIES***

|  |  |
| --- | --- |
| List Drug, Environmental, and Food allergies | Reaction |
|  |  |
|  |  |
|  |  |

***SURGICAL HISTORY***

|  |  |  |  |
| --- | --- | --- | --- |
| Surgery | Month/Year | Surgery | Month/Year |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

***HOSPITALIZATIONS***

|  |  |  |  |
| --- | --- | --- | --- |
| Reason | Month/Year | Reason | Month/Year |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

***FAMILY HISTORY \*\****List relationship to patient (ex: mother, father, sister, brother, maternal/paternal grandmother etc.)\*\*

**\_\_ No family History \_\_ Depression \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_ Patient is adopted \_\_ Diabetes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_ Unknown Maternal History \_\_ Epilepsy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_ Unknown Paternal History \_\_ GERD \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_ Alcoholism \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_ High Blood**

**\_\_ Anemia \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pressure \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_ Asthma \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_ High Cholesterol\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_ Birth Defects \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_ Hypothyroidism \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_ CAD \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_ Kidney Disease \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_ Cardiovascular \_\_ Liver Disease \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Disease \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_ Multiple Births \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_ Cancer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_ OA \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_ Congenital Anomaly \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_ Osteoporosis \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_ COPD \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_ Pulmonary \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_ Crohn’s Disease \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Disease \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_ CVA/TIA \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Name: DOB:**

***Social1History***

Do you Smoke? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How many a day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever smoked?\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Quit Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you drink Alcohol? \_\_\_\_\_\_\_\_\_\_\_\_\_ How often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any Caffeine Use? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any Recreational Drug Use (If so what kind)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Are you a victim or have been a victim of sexual assault/rape? **( ) yes ( )no** Do you wear a seatbelt? **( ) yes ( ) no** Do you exercise **( ) yes ( )no**

***GYN History***

Age of first Period? \_\_\_\_\_\_\_\_\_What is the first day of your last menstrual period? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many days apart are your menstrual cycles? \_\_\_\_\_\_\_\_\_\_\_\_\_ How long did it last? \_\_\_\_\_\_\_\_\_\_

Pain with periods? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Recent changes in period? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently sexually active? ☐ Yes ☐ No ☐ Never With? ☐ Men ☐ Women ☐ Both

Are you currently using birth control? ☐ Yes ☐ No Trying to get pregnant? ☐ Yes ☐ No

Current birth control: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Are you satisfied with it? ☐ Yes ☐ No

When was your last PAP Smear? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had an abnormal PAP? ☐ Yes ☐ No If so, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ What was the abnormality? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had the following?

☐ Colposcopy - Date:\_\_\_/\_\_\_/\_\_\_ ☐Cryosurgery - Date: \_\_\_/\_\_\_/\_\_\_ ☐LEEP - Date: \_\_\_/\_\_\_/\_\_\_

Do you do self-breast exams monthly? ☐ Yes ☐ No

Have you had a mammogram? ☐ Yes ☐ No If so when? \_\_\_\_\_\_\_\_\_\_\_\_\_ Result: \_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had a Bone Density Test? ☐ Yes ☐ No If so when: \_\_\_\_\_\_\_\_\_\_\_\_ Result: \_\_\_\_\_\_\_\_\_\_\_\_ Request to be tested for STD’s, including HIV? \_\_\_ yes \_\_\_no

**\*\*By law all positive results should be reported to the Department of Health of Virginia\*\***

***Obstetric History***

How many pregnancies? \_\_\_\_\_ Full-Term:\_\_\_\_\_\_ Pre-Term:\_\_\_\_\_\_\_ Abortion(s):\_\_\_\_\_\_\_Miscarriages:\_\_\_\_\_\_\_ Live Children: \_\_\_\_\_\_C-Sections: \_\_\_\_\_

Vaginal Deliveries: \_\_\_\_\_\_ Forceps or Vacuums:\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pregnancy #1**- Date\_\_\_\_\_\_\_\_\_\_\_\_\_, M/F\_\_\_\_\_\_\_, weight\_\_\_\_\_\_, gestational age\_\_\_\_\_,

medicated(epidural)\_\_\_\_\_, c/s or vaginal:\_\_\_\_\_\_\_\_\_\_Problems during pregnancy \_\_\_\_\_\_\_\_\_\_\_

**Pregnancy#2**- Date\_\_\_\_\_\_\_\_\_\_\_\_\_, M/F\_\_\_\_\_\_\_, weight\_\_\_\_\_, gestational age\_\_\_\_\_\_,

medicated(epidural)\_\_\_\_\_, c/s or vaginal:\_\_\_\_\_\_\_\_\_Problems during pregnancy\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Name:**

**DOB:**

**Pregnancy #3**- Date\_\_\_\_\_\_\_\_\_\_\_\_\_, M/F\_\_\_\_\_\_\_, weight\_\_\_\_\_\_, gestational age\_\_\_\_\_\_,

medicated(epidural)\_\_\_\_\_, c/s or vaginal:\_\_\_\_\_\_\_\_\_\_Problems during pregnancy\_\_\_\_\_\_\_\_\_\_\_\_

***Review of Symptoms***

**\*\*please check if any of the following apply to you currently\*\***

|  |  |
| --- | --- |
| ** Unexplained Weight change: \_\_\_gain \_\_\_loss**  ** Fever**  ** Dizzy Spells**  ** Trouble with eyes**  ** Nosebleeds**  ** Trouble with nose/sinuses**  ** Chest Pain**  ** Irregular and/or rapid heart beat**  ** Coughing up a lot of phlegm or mucus**  ** Coughing spells**  ** Trouble breathing**  ** Nausea**  ** Vomiting**  ** Constipation**  ** Feeling of incomplete emptying of stools after bowel movement**  ** Involuntary loss of gas or stool**  ** Diarrhea**  ** Blood in stool**  ** Heartburn/Indigestion**  ** Pain with Intercourse**  ** Bleeding with Intercourse**  ** Abnormal vaginal discharge**  ** Vaginal odor, itching, dryness**  ** Irregular periods, heavy periods**  ** Pain or severe cramping with periods**  ** Severe premenstrual symptoms**  ** Bloating and/or excess gas**  ** Pelvic and/ or abdominal pain** | ** Involuntary urine loss**  ** Painful and/ frequent urination**  ** Feeling of incomplete bladder empty**  ** Blood in urine**  ** Trouble with balance**  ** Severe joint or muscle pain**  ** Changes in skin lesions (warts, moles)**  ** Breast pain**  ** Nipple discharge**  ** Migraine headaches**  ** Awaken with headaches**  ** Trouble sleeping**  ** Hot Flashes**  ** Night Sweats**  ** Difficulty Concentrating**  ** Hair loss or thinning**  ** Increased body or facial hair**  ** Decreased sex drive**  ** Difficulty achieving orgasm**  ** Loose feeling of the vagina with or without decreased feeling during sex**  ** Partner complaining of the above**  ** Sensation of something bulging or falling from vagina**  ** Labia (vulvar lips) too long or excessive**  ** Unusual fatigue**  ** Heat or cold tolerance**  ** Frequent bruising** |

**Patient Name:**

**DOB:**

## RESTON WOMEN’S CENTER

## 1850 TOWN CENTER PKWY, SUITE 650, PAVILION II, RESTON, VA 20190

## 703-955-5978│703-830-4188 (f)

## CENTREVILLE OB/GYN

## 14701 LEE HWY, SUITE 304

## CENTREVILLE, VA 20121

## 703-830-4388│703-830-4188 (f)

I, hereby authorize Centreville OB/GYN and /or their

representatives to release any and all information pertaining to my health care, including

test results, procedure, billing and/ or accounting information to the following person (s)

or agencies.

* Myself
* Parents
* Insurance
* No one
* Other (Please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I further authorize the physicians and their representatives to release the results of my

medical exams in one or more of the following ways:

(please check all that apply)

* May call me
* a May NOT call me
* Mail
* At work
* At home
* Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

May leave message to return call to physician’s office:

* At home
* At work
* Voicemail
* None

***I understand that this office will NOT release any information· to those persons who I***

***have not listed without a separate consent. I also understand that this relates to all***

***medical as well as account information. If I wish to make changes to the status of this***

***form, I will do so in writing.***

Patient's Signature Date

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Name:**

**DOB:**

## CENTREVILLE OB/GYN

## 14701 LEE HWY, SUITE 304

## CENTREVILLE, VA 20121

## 703-830-4388│703-830-4188 (f)

## RESTON WOMEN’S CENTER

## 1850 TOWN CENTER PKWY, SUITE 650, PAVILION II, RESTON, VA 20190

## 703-955-5978│703-830-4188 (f)

**NOTICE OF DEEMED CONSENT OF BLOOD TESTING**

A new Virginia law was enacted in 1989 that allows health care providers to test their patients

for HIV antibodies when a health care worker is exposed to the blood or body fluids of a patient

in a way which may transmit human immunodeficiency virus (HIV), the virus which causes AIDS. Because of this law, in the event of such exposure, you will be deemed to have consented to such testing, and to have consented to the release of the test results to the exposed health

worker. Except in emergencies, you **will** be informed before any of your blood is tested for HIV

antibodies, the testing will be explained to you and you will be given the opportunity to ask any

questions you might have. You will be provided with the test results and appropriate counseling. Test results, if positive are required by law to be reported to the Virginia Department of Health.

I have read and understand the above "Notice of Deemed Consent to HIV Blood Testing."

Patient Signature: Date:

\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PRIVACY PRACTICES ACKNOLEDGMENT FORM**

I have been provided an opportunity to review the Notice of Privacy Practice.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Insurance Acknowledgment Form**

I authorize my insurance benefits to be paid directly to the physician and I am financially responsible for all charges. I hereby consent to the

release and re-disclosure of my medical record to enable or facilitate the collection, verification or settlement of my account for any amounts

due from me or any third-party payor, health maintenance organization, insurer or other health benefit plan. This consent applies to Centreville OB/GYN & Reston Women’s Center to

test my blood for hepatitis and/or the AIDS virus, if in their opinion; an employee has suffered an exposure incident as a result of my treatment,

as defined by the Occupational Safety and Health Administration.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Name:**

**DOB:**

## CENTREVILLE OB/GYN

## 14701 LEE HWY, SUITE 304

## CENTREVILLE, VA 20121

## 703-830-4388│703-830-4188 (f)

## RESTON WOMEN’S CENTER

## 1850 TOWN CENTER PKWY, SUITE 650, PAVILION II, RESTON, VA 20190

## 703-955-5978│703-830-4188 (f)

**For Annual/Well-Woman Exam:**

An Annual gynecological exam, known as “preventative management (PM)” for insurance purposes consist of a physical exam (vital signs and examination of the neck, breast, abdomen, pelvic and possibly rectum), collection of a pap smear, and certain age appropriate counseling and testing.

Additional test preformed during this visit include Gonorrhea and Chlamydia screening for women under 25 years old, or with multiple sex partners. If the pap smear is mildly abnormal, an HPV test will be added to the pap smear to determine further follow-up. For women over 30 an HPV screening is performed during the visit. HPV is a sexually transmitted disease (STD). Gonorrhea and Chlamydia are also STD’s ad these infections must be reported to the VA State Board of Health, which may contact you to inform your partner(s) regarding possible infection. Routine blood work is also drawn during this visit (example : cholesterol, TSH, CBC, etc.)

For women over 40 years old, recommended additional testing includes a yearly mammogram and yearly screening for colon cancer. Mammograms are generally covered by insurance ; colon cancer screening or blood work may not be.

For Consultations/Problems:

Consultations regarding current gynecological problems are generally covered, unless your insurance considers the condition “preexisting” to your current insurance coverage. Consultations for certain health maintenance (example: exercise, diet and weight loss), mental status (example: depression, anxiety and sexual dysfunction) may not be covered. It is your responsibility to know the details of what your insurance policy covers.

If you have any questions, please feel free to ask a staff member.

I have read and understand the components and limitations of preventative management as stated above. I am aware that some insurance plans do not cover (pay for) “preventative” or “routine” medical visits, or visits for “preexisting” conditions, in which case I will be responsible for payment to the office and laboratory for services rendered.

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

***Patient Name:***

***DOB:***

## RESTON WOMEN’S CENTER

## 1850 TOWN CENTER PKWY, SUITE 650, PAVILION II, RESTON, VA 20190

## 703-955-5978│703-830-4188 (f)

## CENTREVILLE OB/GYN

## 14701 LEE HWY, SUITE 304

## CENTREVILLE, VA 20121

## 703-830-4388│703-830-4188 (f)

**Patient Responsibilities and Office Policies**

Please read and initial acknowledgment of each office policy below.

**\_\_\_\_\_** Notify us of any changes to your address or insurance information at the time of the change.

**\_\_\_\_\_** All appointments must be scheduled in advance. If you are more than 15 minutes late for an appointment, you will be asked to reschedule.

\_**\_\_\_\_** There is a fee for copying medical records. There is a $10.00 processing fee, plus $0.50 per page, a maximum of $25.00. Records may take up to 14 days to process, so make sure your release form is submitted in the appropriate time frame. (This is only if you are transferring care to another physician).

\_\_\_\_\_ There is a $35.00 fee for all returned checks.

\_\_\_\_\_ Please be advised that we will notify you by mail of **ALL** test results. Test results that require additional testing or that is abnormal will require a consultation appointment to discuss the results.

\_\_\_\_\_ A $10.00 fee is required for all types of disability forms. This fee is also required for letters needed with medical details (i.e. visa letters, denied laboratory services, etc.)

\_\_\_\_\_ A $50.00 charge will be billed to you for failing to keep your appointment and not providing at least 24 hours. A $250.00 charge will be billed to you for failing to provide at least 72-hour cancellation of surgery.

\_\_\_\_\_ Co-payments will be collected at the time of your visit. If you do not have your payment at the time of service, then your visit will be rescheduled. We will not bill you for your co-payment.

\_\_\_\_\_ Self-Pay Patients: All fees for service rendered will be paid in full at the time of your visit. We will not balance bill.

\_\_\_\_\_ The physician’s billing representative will file your office visits. Surgeries and obstetrical care to your insurance. We will complete all requirements to get your claims paid in a timely fashion. However, all claims not paid by your insurance, **WILL** become your responsibility.

\_\_\_\_\_ It is also your responsibility to check with your insurance company to verify that we are a participating provider of your health plan prior to services. We order tests that are medically necessary. It is your responsibility to know what tests your insurance policy covers and does not cover. (This includes all lab and radiology tests). Your office visit does not include the cost of lab or additional procedures (i.e. ultrasound).

\_\_\_\_\_ Know your insurance policy. Every policy has its own rules and regulations. It is in your best interest to know what your benefits are, and if referrals are required. If you come without getting proper referrals or if your

insurance denies your visit stating that it is a non-covered service, you understand that this means you become responsible for this service.

\_\_\_\_\_ If you do not have a valid insurance card (enrollment information will not be acceptable), you will be required to pay in full at the time of service. You will then be responsible for filing a claim with your insurance company for reimbursement. Of you will have to reschedule your appointment.

\_\_\_\_\_ A $15.00 fee is required for **ALL** lost prescriptions and referral forms (i.e. Radiology orders and orders for other doctors).

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ have read, understand, and accept the above policies.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

Thank you in advance for your cooperation and understanding.