CHEAHA WOMEN'S HEALTH AND WELLNESS
Joshua Johannson M.D., FACOG – Obstetrics and Gynecology
office # 256-241-0885 – www.cheahawomen.com

PATIENT NAME: _____BIRTHDATE: _____ DATE COMPLETED: _____

EMERGENCY CONTACT NAME AND PHONE: _____

OB/GYN HEALTH ASSESSMENT SHEET

In order for us to provide quality care to you, we ask that you fill in the answers to the questions below. **All answers will be kept confidential**. We'd like you to feel comfortable about discussing any questions or concerns you have with your doctor or nurse.

Reason for your visit: _____

How did you hear about us? _____

Medications (List all medicines that you take, how much and how often

Allergies (Medicine, food, other)	**Reactions? (Rash, itching, swelling)**

Please check if you have ever had and of the following:

▫ Anemia	▫ Birth Defects of inherited Disease	▫ Cancer- Colon	▫ Diabetes	▫ Heart Conditions	▫ Kidney Disease
▫ Anesthesia Complications	▫ Blood Transfusions	▫ Cancer- Ovarian	▫ Endometriosis	▫ Hepatitis	▫ Lung Disease
▫ Anxiety Disorder	▫ Breast Problem	▫ Cancer- other	▫ GI Problems	▫ High Blood Pressure	▫ Psychiatric Illness
▫ Asthma	▫ Cancer- Breast	▫ Depression	▫ Headaches or Migraines	▫ Infertility	▫ Thyroid Problem
Other:					

LIST ALL SURGERIES AND APPROXIMATE DATES:

	___/___/____
	___/___/____
	___/___/____
	___/___/____
LIST ALL REASONS FOR HOSPITALIZATIONS AND APPROXIMATE DATES:	
	___/___/____
	___/___/____

GYN HISTORY:

Date of Last Period:	Duration of flow (days)	Pelvic Pain: Yes or No *(Circle)*
Age at first period:	Flow: Light, Moderate, Heavy (Circle)	How old were you when you had your first child?
If Post-Menopausal, age at Menopause:	Abnormal pap smear in the past? _____ If yes, explain:	Current Birth Control Method:
Do you menstruate monthly?	Problems with loss of urine? Yes or No *(Circle)*	Desired Birth Control Method:

Has anyone in your family had any of the following? If yes, PLEASE SPECIFY RELATIONSHIP & MATERNAL OR PATERNAL

▫ Alcohol/ Substance Abuse	▫ Diabetes	▫ Lung Cancer	▫ Thyroid Problems
▫ Bleeding Disorder	▫ Genetic Disorder	▫ Osteoporosis	▫ Uterine Cancer
▫ Breast Cancer	▫ Heart Attack (MI)	▫ Ovarian Cancer	▫ Other
▫ Cancer	▫ Heart Problem	▫ Postpartum Depression	
▫ Cervical Cancer	▫ Hypertension/High Blood Pressure	▫ Psychiatric Problems	
▫ Colon Cancer	▫ Immune Disease	▫ Stroke	

SOCIAL HISTORY:

Marital Status:	Do you drink alcohol? Yes or No How often? How much?	Do you use illegal/ recreational drugs?
Occupation:	Do you drink caffeinated beverages? (coffee, tea, soda) Yes or No How much daily?	Are you sexually active? Yes or No *(circle)*
Education:	Diet: regular, vegetarian, vegan, gluten free specific, carbohydrate, cardiac *(circle)*	Have you been sexually active with: men, women, both *(circle)*
Do you exercise? How long? How often?	Smoking Status: Have you used tobacco/smoked (circle): Never Occasional	Do you feel threatened in your current relationship?
General stress level: Low, Medium, High *(circle)*	Former; Quit date: Current smoker; How much?	Have you ever been Physically/ Sexually/ Emotionally abused?

OB HISTORY:

Delivery Date	Vaginal/C-Section	Baby's sex & Weight	Birth Place	Complications	Current Health of Child

WHEN WAS THE LAST TIME YOU HAD ANY OF THE FOLLOWING? (Give approximate date)

Pap Smear	Date:	Where?
Breast Exam	Date:	Where?
Mammogram	Date:	Where?
Colonoscopy	Date:	Where?
Complete Physical	Date:	Where?

We ask for the following information as many insurance payers require us to report it:

Primary Language: _____

Race: _____

Ethnicity: _____

Patient Signature: _____ Date: _____

Reviewed by: _____ Date: _____

Policy of Patient Responsibility for Fees

Thank you for coming to Cheaha Women's Health and Wellness. We believe that good care for you and your family starts with good communication. We have created this policy to help our patients understand the responsibilities that they and their families have for payment of our fees. If at any time you have questions or problems with our fees or payment process, please do not hesitate to talk to Accounts Receivable at 256-241-0885.

Patient Prompt Payment Responsibility

As a courtesy to you, our patient, we may directly submit charges for payment to your insurance company or government program. All costs related to your care, however, are your responsibility.

We require that our patients promptly pay all charges that we present to them. In some cases our fees may be adjusted, based on whether we participate in or accept insurance or government program payments, allowances, or limitations. If we present a charge to you, it means that we have taken such adjustments into account and that you still owe the amount remaining. If you are reimbursed directly by a program for the cost of your care, you must pay our charges promptly, whether or not you have received that reimbursement.

If you do not agree with patient responsibility amounts or reimbursement amounts set by your insurance or government program, this is a matter between you and that program. We are happy to provide you with factual information about your care and billing to help you discuss this with them. We still require you to promptly pay the charge that we present to you, even if you insurance issue is not resolved.

Payment for our services is due at the time that those services are provided to you, and we expect that all charges we present to you will be paid at the time of the visit. This includes (but is not limited to): copay amounts, program deductibles, earlier charges that remain unpaid, and charges for services that are not covered or determined to be your responsibility after coverage payments from your insurance or government program.

We may also present charges to you by written statement via mail, email, or web portal after a visit. If we do this, we expect that each charge will be paid in full the first time that charges are presented to you. You may pay by sending a check by return mail or by calling our office with a credit card payment. We or our agents may send you statements and reminders of charges made and amounts to be paid, or may call you about the same. By accepting our services, you are consenting to receive these communications. If your charges are not paid on time, you will be responsible for any late fees or collection charges that are incurred.

Cancellation/ Rescheduling Responsibility

We are committed to providing medical care to our patients in a timely manner. A last minute cancellation not only delays your care, it prevents us from scheduling another patient that needs to be seen. We ask that if you need to cancel or reschedule you appointment, please do so at least 24 hours in advance. Please note that we will charge a $50 fee for all appointments that are not cancelled or rescheduled at least 24 hours in advance. This fee will not be covered by your insurance and payment will be your responsibility.

Name: (Patient Signature) _____Date:_____

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Pharmacy Form Authorization to Release Health Information

What is the purpose of this Authorization?
This form is used by patients to authorize their pharmacy to release health information to an individual (Dr. Johannson) as required by the Health Insurance Portability Accountability Act ("HIPAA") and other state and federal privacy law.

Patient Information:

Patient Name: _____ Date of Birth: _____

Address: _____

City, State, Zip: _____ Phone: _____

Information to be released: (Please initial below)

___ I authorize the release of the following health information: List of all prescriptions
___ I do not authorize the release of the following health information: List of all prescriptions

Pharmacy and Purpose:

Pharmacy Name: _____ Phone: _____

Street Address: _____ City, State, Zip: _____

The purpose of this Authorization is for: Medical Care

I understand that my patient profile may include information related to treatment of **mental health conditions, alcohol or substance abuse, HIV or AIDS, sexually transmitted diseases, or communicable diseases**. I understand that the information, if any, pertaining to any of the conditions described above may be released. _____ (Please initial)

Signature:

1.) I understand that signing the Authorization is voluntary. Receipt of Pharmacy services will not be conditioned upon my authorization of this disclosure.
2.) I understand that if I authorize the release of my health information to a recipient who is not legally required to keep it confidential, the information may be re-disclosed and may no longer be protected by federal or state privacy laws.
3.) I have the right to revoke this Authorization at any time in writing at Cheaha Women's Health and Wellness.

_____ _____
Signature of Patient or Personal Representative Date

If you have signed this form as a legally authorized representative of the patient, please print your name and relationship to the patient on the lines below.

_____ _____
Name of Personal Representative (Please Print) Relationship to Patient

Cheaha Women's Health and Wellness
Authorization for Release, Use and Disclosure of Health Information

Patient Name: _____ Date of Birth: _____

Address: _____

Phone Number: _____ Fax Number: _____

☐**Access Request to Copy/Inspect**

I authorize the use/disclosure of health information about me as described below:

1. The following organization is authorized to make the disclosure:

   _____
   Name of Facility

   _____
   Address

2. The type of information to be used or disclosed is as follows (please include dates of service)

   Date(s) of Service: _____

   ☐ Complete Medical Record ☐ Abstract of Medical Record (H&P, Discharge Summary, Consultation Reports, Operative & Procedure Reports, EKGs, Laboratory, X-ray and imaging reports)

   ☐ History & Physical (H&P)
   ☐ Discharge Summary
   ☐ Operative Report
   ☐ Consultation Reports
   ☐ X-ray and imaging reports
   ☐ Progress Notes
   ☐ Laboratory Test Results
   ☐ Immunization Record

   ☐ Other- list specific Items: _____

   Behavioral Health Reports:

   ☐ Social History
   ☐ Client Data Form
   ☐ Referral/Treatment Form
   ☐ Admission Evaluation
   ☐ Notification of Admission
   ☐ Treatment Plan
   ☐ Academic History
   ☐ Aftercare Instructions
   ☐ Psychological Evaluation

   ☐ Other – list specific items: _____

3. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment of alcohol abuse.
   This information is being provided to you from records whose confidentiality may be protected by State and/or Federal law.

4. I understand that your facility may receive compensation for medical record copying in accordance with State law.

5. This information may be disclosed to and used by the following individual/organization:
   Name: Cheaha Women's Health and Wellness
   Address: PO BOX 2610
   Anniston, AL 36202
   Phone number: (256) 241-0885
   Fax number: (256) 847-8536

   For the purpose of:

   ☐ Further Medical Care ☐ Insurance Eligibility/Benefits
   ☐ Inspection/Copying of my records ☐ Legal Investigation or Action
   ☐ Personal ☐ Changing Physicians
   ☐ Other (please specify):_____

6. I understand I have the right to inspect and obtain a copy of my protected health information in the designated record sets you or your business associates maintain. I understand however I am not entitled to inspect or obtain a copy of any psychotherapy notes or any information compiled in anticipation of use of or for any civil, criminal or administrative action or proceeding, any information not subject to disclosure under the Clinical Laboratory Improvements Amendments of 1988, (42 U.S.C. section 263 (a), and certain other records.

7. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used or disclosed under this authorization as described in #6 above.

8. I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected under the terms of this authorization.

9. I understand that I may revoke this authorization in writing at any time. To understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. **This authorization expires within 90 days, unless otherwise specified.**

_____ _____
Signature of Patient Date

(If signed by someone other than the patient, indicate relationship and authority to do so.)

_____
Name of Patient (Please Print)

Patient is:
☐ Minor ☐ Incompetent
☐ Disabled ☐ Deceased

Legal Authority:
☐ Custodial Parent ☐ Legal Guardian
☐ Executor of Estate of Deceased ☐ Power of Attorney for Health Care
☐ Authorized Legal Personal Representative

_____ _____
Signature of Witness Date

Cheaha Women's Health and Wellness
Acknowledgement of Privacy Notice &
Consent for Purposes of Treatment, Payment, and Health Care Operations

I consent to the use or disclosure of my protected health information by Cheaha Women's Health and Wellness for the purpose of diagnosing or providing treatment to me, obtaining payment of my health care bills or to conduct health care operations of Cheaha Women's Health and Wellness. My "protected health information" means medical, billing, and demographic information about me collected from me and created or received by Cheaha Women's Health and Wellness for treatment, payment, and healthcare operations. I understand that diagnosis or treatment of me by Cheaha Women's Health and Wellness may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operation of the practice. Cheaha Women's Health and Wellness is not required to agree to the restrictions that I may request. However, if Cheaha Women's Health and Wellness agrees to a restriction I request, the restriction is binding on Cheaha Women's Health and Wellness. I have the right to revoke this consent, in writing, at any time. The revocation will be effective upon receipt, except to the extent that Cheaha Women's Health and Wellness has taken action in reliance on this consent.

I understand I have a right to review Cheaha Women's Health and Wellness's Notice of Privacy Practices prior to signing this document. Cheaha Women's Health and Wellness's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operation of Cheaha Women's Health and Wellness. The Notice of Privacy Practices for Cheaha Women's Health and Wellness is also provided in various locations of the facility, to include the waiting room. The Notice of Privacy Practices also describes my rights and Cheaha Women's Health and Wellness's duties with respect to my protected health information.

Cheaha Women's Health and Wellness reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or by asking for one at the time of my next appointment.

Print Name of Patient

_____

Signature of Patient

_____

Date

Names of persons we may communicate with:

_____ Phone #_____

_____ Phone #_____

_____ Phone #_____

Check All That Apply:

- € Do not call at home.
- € Do not call at work.
- € Do not mail reminder cards.
- € Do leave messages on voice mail/answering machine.
- € Do leave messages with persons who answer.

Cheaha Women's Health and Wellness
Office Policies

Cell Phone Consent

_____ In order for Cheaha Women's Health and Wellness to service my account with appointment reminders or notify me of account balances due, I agree that Cheaha Women's Health and Wellness and/or their agents may contact me by telephone at any telephone number associated with my account, including wireless telephone numbers, which I understand could result in charges to me. I also agree that Cheaha Women's Health and Wellness may also contact me by sending text messages to my phone or emails, using any email address I provided to Cheaha Women's Health and Wellness. Methods of contact may include using prerecorded/artificial voice messages and/or use of automatic dialing devices, as applicable.

Collection Fees

_____ I the agree to accept any collection fee charges as a legal and lawful debt and agree to pay said fee, including any/all collection agency fees, (32%), attorney fees and/or court costs, if collection action are necessary.

Cancellation /No Show Fee

_____ I understand that I am to provide a 24 hour cancellation notice in the event I am unable to make a scheduled appointment, so that others that need to be seen can be scheduled. I also understand that if I do not keep my appointment or fail to cancel it with a 24 hour notice, that I am responsible for a $50.00 no-show fee.

_____ _____

Patient Signature Date

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Cheaha Women's Health and Wellness
Laboratory Consent

This notice is to inform all of our patients that Cheaha Women's Health and Wellness uses **QUEST** primarily and **LABCORP** secondary to submit all of our specimens. If you need to use another lab that is not listed, or if your insurance requires a specific lab, **please let us know before specimens are collected**.

_____ _____

Patient Signature Date

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Email Communication Consent Form

Dear Patient:
Please carefully read the following consent form about email communication from this office. Once you have read the information please sign the form to indicate that you agree to the conditions in this consent form. If a signed consent if not present in your chart, we will not use emails to communicate with you and any email address we have for you will be removed from your file.

Risks of using email:
While the opportunity to communicate by email enhances your care, transmitting patient information poses several risks of which you should be aware. You should not agree to communicate with the physician via email without understanding and accepting these risks. The risks include, but are not limited to, the following:
• The privacy and security of email communication cannot be guaranteed.
• Employers and online services may have a legal right to inspect and keep emails that pass through their System.
• Email is easier to falsify than handwritten or signed hard copies. In addition, it is impossible to verify the true identity of the sender, or to ensure that only the recipient can read the email once it has been sent.
• Emails can introduce viruses into a computer system, and potentially damage or disrupt the computer.
• Email can be forwarded, intercepted, circulated, stored or even changed without the knowledge or permission of the physician or the patient. Email senders can easily misaddress an email, resulting in it being sent to unintended and unknown recipients.
• Email is indelible. Even after the sender and recipient have deleted their copies of the email, back-up copies may exist on a computer or in cyberspace.
• Use of email to discuss sensitive information can increase the risk of such information being disclosed to third parties.
• Email can be used as evidence in court.

Conditions of using email:
The physician will use reasonable means to protect the security and confidentiality of email information sent and received. However, because of the risks outlined above, the physician cannot guarantee the security and confidentiality of email communication. Therefore your consent is required to use email for transfer of patient information. Consent to the use of email includes agreement with the following conditions:
• Emails to or from the patient concerning diagnosis or treatment may be printed in full and made part of the patient's medical record. Because they are part of the medical record, other individuals authorized to access the medical record, such as staff and billing personnel, will have access to those emails.
• Emails may be forwarded internally to the physician's staff and to those involved, as necessary, for diagnosis, treatment, reimbursement, healthcare operations, and other handling. The physician will not, however, forward emails to independent third parties without the patient's prior written consent, except as authorized or required by law.
• Although the physician will endeavor to read and respond promptly to an email from the patient, **the physician cannot guarantee that any particular email will be read and responded to within any particular period of time. Thus, you should not use email for medical emergencies or other time sensitive matters.**
• Email communication is not an appropriate substitute for clinical examinations. You are responsible for following up on the physician's email and for scheduling appointments where warranted.
• If your email requires or invites a response from the physician and you have not received a response within a reasonable time period it is the your responsibility to follow up to determine whether the intended recipient received the email and when the recipient will respond.
• You should not use email for communication regarding medical information that you deem sensitive.

Specifically, positive test results for sexually transmitted diseases including HIV will not be released by email. Negative test results for sexually transmitted diseases **will** be sent by email. **The physician will use his discretion with regard to other sensitive matters and their appropriateness for email communication.**

• If you have any concerns about medical information being sent by email you should not consent to email communication.

• The physician is not responsible for information loss due to technical failures associated with the patient's email software or internet service provider

Instructions for communication by email:

To communicate by email, you shall:

• Limit or avoid using an employer's or other third party's computer.

• Inform the physician of any changes in your email address

• Include in the email the category of the communication in the email's subject line, for routing purposes (e.g., "blood pressure readings") and include your name in the body of the email when it is not obvious from the email address itself.

• Review the email to make sure it is clear and concise and that all relevant information is provided before sending to the physician.

• Inform the physician when you receive an email when directed by the physician or his staff.

• Take precaution to preserve the confidentiality of emails, such as using screen savers and safeguarding computer passwords.

• Withdraw consent of email communication in writing to the physician.

• **Do not use email when you require immediate assistance, or if you condition appears serious or rapidly worsens. Rather you should call the office or take other measures as appropriate.**

Patient acknowledgment and agreement.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of email between the physician and me, and consent to the conditions outlined herein, as well as any other instructions that the physician may impose to communicate with patients by email. I acknowledge the physician's right to, upon the provision of written notice, withdraw the option of communicating through email. Any questions I may have had were answered.

Patient name: _____

Patient address: _____

Patient email: _____

Patient signature: _____ Date: _____

Witness signature: _____ Date: _____

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MEDIA RELEASE FORM

I, _____, grant permission to Cheaha Women's Health and Wellness, hereinafter known as the "Media" to use my image (photographs and/or video) for use in Media publications including:

(Check All That Apply)

❏- Videos ❏- Email Blasts ❏- Social Media (Instagram, and Facebook) ❏- Newsletters ❏- Magazines ❏- General Publications ❏- Website and/or Affiliates ❏- Other: _____

I hereby waive any right to inspect or approve the finished photographs or electronic matter that may be used in conjunction with them now or in the future, whether that use is known to me or unknown, and I waive any right to royalties or other compensation arising from or related to the use of the image.

Please **initial** the paragraph below which is applicable to your present situation:

_____ - I am 20 years of age or older and I am competent to contract in my own name. I have read this release before signing below, and I fully understand the contents, meaning and impact of this release. I understand that I am free to address any specific questions regarding this release by submitting those questions in writing prior to signing, and I agree that my failure to do so will be interpreted as a free and knowledgeable acceptance of the terms of this release.

_____ - I am the parent or legal guardian of the below named child. I have read this release before signing below, and I fully understand the contents, meaning and impact of this release. I understand that I am free to address any specific questions regarding this release by submitting those questions in writing prior to signing, and I agree that my failure to do so will be interpreted as a free and knowledgeable acceptance of the terms of this release.

Signature: _____ Date: _____

Name (please print): _____

Address: _____

Signature of parent or legal guardian: _____
(if under 20 years of age)