Greetings from Barton Women's Health
Health care is personal and we know you have many choices in your care. Thank you for choosing the practice of Barton Women's Health for your gynecological and/or obstetric care. We look forward to seeing you and taking part in your medical care with us. Below are a few items to assist you with your care in this office:

Prescription Refills:
In order to help us properly process your requests we ask that you contact your pharmacy first and have them fax us a refill request. We strive to renew refills the same day, but this may not always be possible. In some cases it may take up to 72 hours to process a refill. If you have an ongoing prescription or a medication you take daily be sure to call at least a week prior to running out to avoid any disruption in your medication. Generally prescriptions are not called in or refilled over the weekend. Not all medications are covered, so please bring a copy of your formulary to your appointment, so a covered medication can be prescribed, if possible.

Schedule Appointments:
You've heard the cliché before: An ounce of prevention is worth a pound of cure. It gets repeated so often because it's true. Most medical conditions benefit greatly from early detection. By scheduling annual visits with your doctor, you can feel confident you're doing everything you can to address issues before they become dangerous. If you have issues between your annual visits, please call to schedule an appointment. Never be afraid to ask questions if you don't understand something your doctor has said. We will make every effort to provide you with an appointment in a timely manner; however we do not always have the capability to accommodate same day appointments. While we do understand unforeseen issues may arise we ask that you try to schedule in advance for routine appointments.

Office Hours:
Monday – Friday from 8:30 am – 5:00 pm, but are closed for major holidays.

Emergencies:
The phone number for Barton Women's Health is the same, day or night – 530-543-5711. When calling after hours, our answering service may be able to contact either your own physician, or another trusted physician. The physician on call may not be immediately available. If you do not receive a call back in a timely manner, you have the option to go to the nearest emergency room, or call 911.

Again, we thank you for choosing Barton Women's Health for your health care needs.

Sincerely,

Our physicians and staff

Barton
Women's Health

PATIENT INFORMATION

Patient ID #: _____ Sex [ ] Male [ ] Female

Name: _____ Social Security #: _____ DOB: _____

Mailing Address: _____ Marital Status: [ ] Married [ ] Single [ ] Divorced [ ] Other

Street Address: _____ Email Address: _____

City, State, ZIP: _____ Primary: [ ]Home [ ]Work [ ]Cell: _____

Secondary: [ ] Home [ ] Work [ ] Cell: _____

Primary Care Physician: _____ Phone Number: _____

Ethnicity: Hispanic □ Non-Hispanic □ Refused □ Race: _____ Religion: _____

PATIENT EMPLOYMENT

[ ] Employed [ ] Retired [ ] Unemployed [ ] Self

Employer: _____

Job Title: _____

Phone: _____

PERSONAL / EMERGENCY CONTACTS

Name Relationship Phone

_____

_____

_____

GUARANTOR/RESPONSIBLE BILLING PARTY

[ ] Same as Patient

Name: _____

Address: _____

City, State, ZIP: _____

Phone: _____

RESPONSIBLE BILLING PARTY EMPLOYMENT

Employer: _____

Work Phone: _____

Social Security #: _____

Date of Birth: _____

PRIMARY INSURANCE Subscriber: [ ] Patient [ ] Responsible Billing Party [ ] Other

Subscriber Name: _____ Relationship to Patient: _____

Subscriber DOB: _____ Subscriber Social Security #: _____

Insurance Co.: _____ Insured ID: _____ Group #: _____

SECONDARY INSURANCE Subscriber: [ ] Patient [ ] Responsible Billing Party [ ] Other

Subscriber Name: _____ Relationship to Patient: _____

Subscriber DOB: _____ Subscriber Social Security #: _____

Insurance Co.: _____ Insured ID: _____ Group #: _____

ASSIGNMENT OF INSURANCE BENEFITS AND RELEASE OF MEDICAL INFORMATION:
I GIVE MY CONSENT FOR TREATMENT.

I herby authorize the release of any appropriate medical information to my insurance company; I assign all medical and/or surgical benefits, including major medical benefits to which I am entitled, including Medicare, private insurance and other health plans. This assignment will remain in effect until revoked by me in writing.

Signature: _____ **Date:** _____

We make every reasonable effort to obtain pre-approval, prior authorization and referral information. Your co-payment, co-insurance and/or deductible are due in full at the time of service. We will bill your insurance as a courtesy to you. On denied worker compensation claims, the patient's private/group health insurance may be billed. Ultimate financial responsibility remains with the patient and if the insurance company or worker compensation carrier denies payment, the bill is your responsibility. If you are unsure of any of these issues, please ask the staff before you see the physician.

Health Questionnaire

Name_____ **Date**___/___/_____ **Age**____

Reason for Visit: □ Annual □ Referral □ Other _____

Pregnancies:
Total number of pregnancies: _____
Miscarriages: _____ Abortions: _____ Births: _____

General Health Information:
First day of last menstrual period: ___/___/_____ OR □ menopausal
Last pap smear (month/year): ___/_____ OR □ never done
Last mammogram (month/year): ___/_____ OR □ never done
Contraception: _____
Last colonoscopy (month/year): ___/_____ OR □ never done
Last bone density (month/year): ___/_____ OR □ never done

Vaccinations:
Last Influenza (month/year): ___/_____ OR □ never done
Gardasil (month/year): ___/_____ OR □ never done
(for <35 years of age)

Gynecological Problems:
□ None □ Abnormal bleeding □ Pelvic pain □ Urinary problems □ Pregnancy
□ Vaginal irritation/discharge □ Hormonal □ Other

Gynecological History:
Age menses started: _____
Menses: □ not applicable
Interval: □ 28-day cycle □ ____day cycle □ Irregular
Duration: _____ days
Flow: □ light □ medium □ heavy □ heavy with clots
Pain with menses: □ none □ mild □ moderate □ severe
Exposure to STDs: □ No □ Yes
History of abnormal pap: □ No □Yes

Pregnancy History: □ Never been pregnant
1 preg: □ miscarriage □ abortion □ vag □ C-sec year:_____ weight: _____
2 preg: □ miscarriage □ abortion □ vag □ C-sec year:_____ weight: _____
3 preg: □ miscarriage □ abortion □ vag □ C-sec year:_____ weight: _____
4 preg: □ miscarriage □ abortion □ vag □ C-sec year:_____ weight: _____
5 preg: □ miscarriage □ abortion □ vag □ C-sec year:_____ weight: _____

Past Medical History: Primary Care Physician: _____ ***OR*** □ None
Current Medical Problems: □ None
□ Anemia □ Asthma □ Diabetes □ Depression □ High Blood Pressure
□ High Cholesterol □ Hypothyroidism □ Other_____

Surgical History:
Gynecological Surgeries: □ ***None***
1st surgery: Type:_____ Year:_____
2nd surgery: Type:_____ Year:_____
3rd surgery: Type:_____ Year:_____
4th surgery: Type:_____ Year:_____
5th surgery: Type:_____ Year:_____
Other Surgeries: □ ***None***
1st surgery: Type:_____ Year:_____
2nd surgery: Type:_____ Year:_____
3rd surgery: Type:_____ Year:_____
4th surgery: Type:_____ Year:_____
5th surgery: Type:_____ Year:_____

Allergies to Medications: □ None Known □Yes_____

Medications: □ None
Prescription: _____
Over the Counter: _____

Family History:
Father: □ Alive □ Deceased
Health Problems:_____
Mother: □ Alive □ Deceased
Health Problems:_____
Siblings: □ None Number:_____
Health Problems:_____

Social History:
Martial Status: □ Married □ Single □ Divorced □ Separated □ Engaged □ Widowed
Sexual History: □ Currently Active □ Not Currently Active □ None □ History of Abuse
Tobacco Use: □ Never □ Current (amount) _____ □ Past (year quit) _____
Alcohol Use: □ Seldom/rare □ Current (amount) _____ □ Previous User (year quit) _____
Caffeinated Beverages: □ Never □ Current (amount)_____
Other Drug Use: □ Marijuana □ Cocaine □Amphetamines □ IV drugs □ Prescription drugs
□ History of Substance Abuse □ Other_____

Are you currently having problems or have questions about the following:

Weight change	_____	Diet	_____
Skin changes	_____	Problems with urination	_____
Ear, sinus or vision	_____	Constipation	_____
Chest pain	_____	Headaches	_____
Irregular heartbeat	_____	Depression	_____
Cholesterol	_____	Pelvic pain	_____
Stomach problems	_____	Abnormal bleeding	_____
Any other problems?	_____	Coughing or shortness of breath	_____

Patient Record of Disclosures

Please fill out completely*

Patient Name:	**Date of Birth:**
Who may we release medical information to: **Name:** _____ **Relationship to you:**_____ **Name:** _____ **Relationship to you:** _____ **Name:** _____ **Relationship to you:** _____	

I wish to be contacted in the following manner (check all that applies):

- ☐ **Home Telephone** _____
  - Okay to leave message with detailed information
  - Leave message with call back number and name of Barton Women's Health only
- ☐ **Work Telephone** _____
  - Okay to leave message with detailed information
  - Leave message with call back number and name of Barton Women's Health only
- ☐ **Cellular Phone** _____
  - Okay to leave message with detailed information
  - Leave message with call back number and name of Barton Women's Health only
- ☐ **Other** _____

Signature _____ ***Date*** _____

Barton
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Preferred Lab

If we send out specimens from our office, i.e., pap smears, blood draws, pathology, etc., your insurance company may have a preference and your benefits could be affected. Please indicate which lab is contracted with your insurance company. If you do not know, please ask one of our receptionists.

_____ Barton

_____ Lab Corp

_____ Quest Diagnostics

_____ OTHER - Lab Name & Address:_____

Pharmacy:
_____

Print Name:
_____

Signature:
_____

Date:
_____

Pap smear
Patient Advisory and Consent

What is a Pap smear?

- The Pap smear is a cancer screening test that has reduced the death rate from cancer of the cervix by 70% in the last fifty years. Cells are collected from your cervix (a part of the uterus, or womb) and smeared on a glass slide. A trained technician examines those cells through a microscope looking for cancer cells, or cells that could become cancerous.

Are all abnormal cells found?

- No. The Pap smear test is 75-85% accurate, but it is not perfect.
- Sometimes abnormal cells that may be present on your cervix are not recognized in the laboratory.
- For these reasons, ***you should have a Pap smear test every two years.***

What causes the laboratory error?

- The technician examining the slide must look at more than 100,000 cells. Often only a few of these are abnormal. Examining a Pap smear can be likened to standing on a balcony overlooking a courtyard with 1,000 Dalmatians and trying to spot the one with the off-color markings in a period of five minutes.
- Even under the best circumstances, at least 5 out of 100 ***abnormal*** Pap smears may be read as normal.
- Occasionally, cells that are actually normal are misidentified as abnormal.

What should I do?

- Have a Pap smear test every year. If your doctor recommends one more often, follow your doctor's advice.
- Report to your doctor any abnormal signs such as excessive discharge, bleeding that is heavier than usual for your menstrual period, or bleeding that occurs after intercourse. A normal Pap smear test does not mean that you can ignore these symptoms.
- The decision as to which lab your specimen is sent is in many cases determined by your insurance carrier.

Inadequate cells?

- On occasion, the lab may require more cells to make an appropriate determination than was received with the original specimen. In these cases, the lab may be unable to make a determination and additional cells may be required. If this is the case, you will be asked to return to the office so another sample can be collected. ***PLEASE NOTE: There IS a charge for this visit.***

Patient Consent:

I certify that I have read the above and will discuss with my physician any questions I may have.

_____

Patient Signature

NOTE: You will be receiving a separate bill from the lab for your Pap smear.

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Financial Policy

Thank you for choosing us as your healthcare provider. We are committed to providing you with proper and optimal care and treatment necessary to maintain and restore your health. In order to achieve these goals we need your assistance and understanding of our payment policy.

All charges are your responsibility regardless of insurance coverage. Not all services are covered by all contracts. Some insurance carriers arbitrarily select certain services they will not cover. While we make every attempt to know plan provisions and benefits for major employers, we cannot accept responsibility for knowing what each carrier will or will not pay. We refer patients to participating providers whenever possible, however the status of these providers changes frequently. Please take the time to familiarize yourself with providers to whom you may be referred (anesthesiologists, pathologists, labs, etc.) and indicate your preference.

Please be certain we have a copy of your most recent insurance card. Policies are updated often and even a subtle change can impact the timely and accurate processing of your claim.

Please note – if your specimen (Pap test, biopsy, lab test) is sent to an outside provider, you will be *billed separately by their office* for these services.

Payment of co-payments and deductibles are due at the time of service. We accept cash, checks, MasterCard and Visa.

Again, thank you for choosing Barton Women's Health for your healthcare needs. If you have any questions about the above information, please feel free to contact a staff member. We appreciate your trust in us and the opportunity to serve you.

* *

I ______________________________ have reviewed the financial policies of Barton Women's Health. I understand I am responsible for all charges for medical services not paid by my insurance plan. To the extent permitted under applicable law, I authorize release of any information relating to my claim(s).

__________________________________ ______________
Signature of Patient Date

____
Print Patient Name

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New federal regulations under the Health Insurance Portability and Accountability Act (HIPPA of 1996) require that all patients be made aware of how their Private Health Information (Medical Records) is accessed, used and disclosed. In accordance with these new HIPPA regulations effective April 14, 2003, Barton Women's Health is required to make available to all patients a "Notice of Privacy Policies."

I have been offered and have available to me a copy of Barton Women's Health "Notice of Privacy Policies."

_____ _____
Patient Signature Date

_____
Print Name