Clarksville Women's Center
1100 E. Poplar St., Ste. A
Clarksville, AR 72830

Dear Patient:

Enclosed is a packet of paperwork for you to complete and bring with you to your appointment.

Shannon Case, M.D. _____

Maranda Hickey, APRN _____

Date/Time: _____

Bringing your paperwork in complete will decrease your wait time.

Please bring your insurance card and photo I.D.

Masks are required at this time.

Feel free to call the office with any questions: 479-754-5337.

Clarksville Women's Center

Patient Health History

Name: _____ DOB: _____ Date: _____

Past Medical History

Please place an "x" by all that apply.

Gynecologic:			**Neurological/Psychiatric:**	
Endometriosis			Migraines	
Fibroids			Depression	
Ovarian cysts			Bipolar Disorder	
History of abnormal Pap Smears				
Pelvic Organ Prolapse				
Other:			**Musculoskeletal:**	
			Osteoporosis	
Infectious Disease:			Fractures	
Gonorrhea			Arthritis	
Chlamydia				
Hepatitis B			**Renal:**	
Hepatitis C			Kidney Stones	
HIV (AIDS)			Bladder infection	
HPV			Other:	
Herpes				
Other:			**Gastrointestinal:**	
			Irritable Bowel Syndrome	
Cardiovascular:			Gastroesophageal Reflux Disease	
Heart disease			Ulcers	
High Blood Pressure			Crohn's Disease	
Heart murmur			Ulcerative Colitis	
Stroke			Diverticulosis	
Other:			Other:	
Respiratory:			**Cancer:**	
Asthma			Breast Cancer	
Pneumonia			Ovarian Cancer	
Pneumonia			Cervical Cancer	
COPD			Uterine Cancer	
Other:			Colon Cancer	
			Skin Cancer	
Endocrine:			Lung Cancer	
Diabetes			Other:	
Thyroid Disease				
Other:				

Past Surgical History
Please list all previous surgeries:

	Year	Procedure
1.		
2.		
3.		
4.		
5.		

Medications
(prescription medications only)

Medication	Dose (mg)	Times Taken Per Day

Drug Allergies and Reactions

Drug	Allergic Reaction

Family Medical History
Please place an "x" by any medical conditions in your immediate family (blood relatives):

Medical Conditions			
Diabetes		Osteoporosis	
Stroke		Breast Cancer	
Heart Disease		Ovarian Cancer	
High Blood Pressure		Colon Cancer	
Thyroid Disease		Other:	

Date of Last Screening Or Immunization

Pap Smear		Glucose	
Mammogram		Thyroid	
Bone Density		Tetanus	
Colonoscopy		Flu Shot	
Cholesterol		Pneumonia	
Other			

Tobacco Use **Please Check One**

Never	Current	Former
Amount Used		
Age Started		
Age Stopped		

Alcohol Use **Please Check One**

Never	Current	Former
Amount Used		
Age Started		
Age Stopped		

Recreational Drug Use **Please Check One**

Never	Current	Former
Amount Used		
Age Started		
Age Stopped		

Seat Belt Use **Please Check One**

Always	Sometimes	Never

Regular Exercise **Please Check One**

Yes	No

Social History

Marital Status	
Number of people living in house	
Level of School Completed	
Current or most recent job	

Reproductive History

First Day of Last Menstrual Period	
Age of First Menstruation	
Do you have monthly cycles?	
Duration of Menstruation	
Are you sexually active?	
If so, what do you use for birth control?	

Number of:

Pregnancies		Abortions	
Miscarriages		Births	

Details of Past Pregnancies

Date	GA – weeks	Length of Labor	Birth Weight	Sex M/F	Type of Delivery	Anesthesia	Hospital	Preterm Labor?	Problems/ Comment

Patient Name_____

Date of Birth_____Today's Date_____

Physician Name_____

Cancer Family History

MEDICARE PATIENTS: Do you have a personal history of Breast, Ovarian, Colon, Uterine, or Prostate cancer? YES NO

INSTRUCTIONS FOR COMMERCIAL INSURANCE AND MEDICAID PATIENTS:

Please consider all relatives (listed below) from BOTH your Mother's and Father's side of the family, BOTH male and female: Father, mother, brothers, sisters, half-siblings, your children, Grandparents, Aunts, Uncles, Nieces, Nephews, Cousins, Great Aunts and Uncles

Circle **Yes** or **No** below:

1) Have **you** or any of the **above relatives** had **BREAST** cancer diagnosed at age **49 OR YOUNGER**? YES NO

2) Have **you** or any of the **above female relatives** had OVARIAN Cancer? YES NO

3) Have you had **THREE** or more relatives listed above (can include you) with **BREAST** cancer on the **SAME** side of the family? YES NO

4) Have you had **THREE** or more relatives (can include you) with any of the following cancers: **COLON or UTERINE** on the **SAME** side of the family? YES NO

5) Were any of the relatives with breast cancer **MALE**? YES NO

6) Has anyone in your family (including you), that you know of, had hereditary cancer testing (i.e. BRCA mutation or Lynch Syndrome) and tested positive for a genetic mutation? YES NO Unsure

7) Are you Ashkenazi Jewish ancestry, diagnosed with breast, ovarian or pancreatic cancer at any age? YES NO

OFFICE USE ONLY

Patient appropriate for testing ☐ Accepted ☐ Declined ☐

Patient does not meet criteria ☐

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NAME: _____
First MI Last

Mailing
ADDRESS: _____
Street or P.O. Box City State Zip

Physical
ADDRESS: _____

HOME PHONE: _____ CELL: _____

_____ **I authorize you to text appointment reminders to cell number provided.**
_____ **I authorize you to leave a message on the numbers I have provided.**

DATE OF BIRTH: _____ SOCIAL SECURITY #: _____

Primary Care Physician: _____ Preferred Pharmacy: _____

LANGUAGE: English Spanish Other: _____ Decline to answer: _____

RACE: _____ Caucasian _____ Black/African American _____ American Indian _____ Asian
_____ Native Hawaiian or Other Pacific Islander Other: _____
_____ Decline to answer

Ethnicity: (Please check one):

_____ Hispanic or Latino _____ Not Hispanic or Latino _____ Decline to answer

MARITAL STATUS: S/M/D/W/Separated PATIENT EMPLOYER: _____

SPOUSE'S NAME: _____ SPOUSE'S DOB: _____

SPOUSE'S SS#: _____ SPOUSE'S EMPLOYER: _____

Email address: _____

May we email you? Yes No

This is used to communicate through the patient portal. You will receive a link prompting you to create a portal account should you provide your email address.

Insurance Information

Policy Holder: _____ Relationship to patient: _____

DOB: _____ SSN: _____

Policy Holder's Employer: _____

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Privacy Policy

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFIT:
I authorize the release of all medical records to referring physicians and to my insurance company. I further authorize insurance payments to be made directly to Clarksville Women's Center. I consent to the use or disclosure of my protected health information by CWC for the purpose of diagnosing or providing treatment for me, obtaining payment for my healthcare bills or to conduct healthcare operations of CWC. I give my permission for necessary laboratory tests to be done or ordered. I agree that I will be personally and fully responsible for the payment of all such testing. I have the right to revoke this consent in writing at any time, except to the extent that CWC was taking action in reliance on this consent. The Notice of Privacy Practices has been provided to me.

Please list any person or persons whom you authorize us to share any personal information with along with their phone numbers:

Name: _____ Phone Number: _____

Relationship: _____

Name: _____ Phone Number: _____

Relationship: _____

Name: _____ Phone Number: _____

Relationship: _____

Signature of Patient or Guardian: _____ **Date:** _____

Clarksville Women's Center
Financial & Appointment Policy

Thank you for choosing Clarksville Women's Center for your care. We are committed to providing you with quality and affordable healthcare. Your clear understanding of our payment/appointment policy is important to our professional relationship. Please read it, ask us any questions you may have, and sign and date in the space provided. A copy will be provided to you upon request.

INSURANCE

Coverage. We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with but you don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. You should know the coverage benefits of your policy, if we are in your network, and whether a referral is required at the time of the visit.

Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please uphold your obligation by paying your share at each visit. If you are covered by Medicare and you do NOT have a supplemental policy, you will be expected to pay your co-payment on the date of service. If you have Medicaid pending, you are still responsible for services on the date of service. If you get retro-Medicaid, we will file for services covered and refund you after Medicaid pays your claims. We accept cash, check, money order, Visa, MasterCard, and Discover.

Non-covered services. Please be aware that some—and perhaps all—of the services you receive may not be covered or considered reasonable or necessary by Medicare, Medicaid, ARKids, or other insurers. You must pay for these services in full at the time of your visit.

Proof of Insurance. We must obtain a copy of your current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information, you may be responsible for the balance of your charges. If your insurance changes, please notify us before your next visit so we can make appropriate changes to help you receive your maximum benefits.

Claims Submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. If your insurance company does not pay your claim within 45 days, the balance will automatically be billed to you. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

PRIVATE PAY. Payment in full is expected at each visit. At check-in, staff will estimate and collect your share based on the reason for your visit. If you cannot pay you may be asked to reschedule your visit. At check-out, we will collect the remaining balance minus the amount that you pre-paid.

NONPAYMENT. If your account is over 60 days past due, you will receive a letter stating that you have 10 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you will be discharged from this practice until the balance is paid in full. If this is to occur, you will be notified by regular or certified mail. Returned checks will be charged a $30 fee.

MISSED APPOINTMENTS. If you are a new patient and miss two appointments without canceling the day before the appointment or within an hour or more of an appointment made that day, we may not schedule you for a third appointment. If you are an established patient and miss two appointments within a three month period without canceling the day before the appointment or within an hour or more of an appointment made that day, you may be discharged from the practice. If this is to occur, you will be notified by regular or certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be available to you on an emergency basis.

I have read and understand the payment/appointment policy and agree to abide by its guidelines.

Signature: _____ **Date:** _____

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WELLNESS VISIT POLICY

Wellness policies stated in your insurance guidelines cover a yearly well woman exam which includes **ONLY THE FOLLOWING:**

- Pap Smear
- Pelvic Exam
- Breast Exam
- Scheduling of Mammogram

Other complaints addressed with the physician during your visit will be billed as a separate charge and may not be covered by the wellness policy clause of your insurance provider. PELVIC ULTRASOUNDS and HORMONE PANELS are NOT covered under preventive services.

Wellness coverage for patients with Medicaid:

- Pap Smear and/or Pelvic Exam and Breast Exam with Contraceptive Counseling & Management of Birth Control (including IUD)
- Scheduling of Mammogram

Arkansas Medicaid of any type will not cover the Mirena, Paragard, Kyleena, Liletta, or Nexplanon, or the insertion of the device for any reason other than family planning/birth control. The use of the IUD to control bleeding will not be covered by Medicaid.

Wellness coverage for patients with Medicare:

Medicare only covers one wellness visit every 2 years with the exception of patients with a personal history of female cancer, at which time yearly wellness visits are covered.

Medicare will not cover the Mirena, Paragard, Kyleena, Skyla, Liletta, or Nexplanon, or the insertion of the device.

I agree to the terms stated above and understand that I am responsible for any additional fees that are not covered under my insurance provider's wellness policy.

Signed: _____ **Date:** _____