VITALITY HEALTH

302-643-2500

PATIENT INFORMATION		
Name		Date of Birth
Address:		City:
State / Zip		
Cell Phone		SSN
Email Address (Required to access patient portal)		
Gender		Married Single Widowed Divorced
Ethnicity	Not Hispanic or Latino	Hispanic or Latino
Race	White Black or African Amer	Native American Asian Other
IF THE PATIENT IS A MINOR (UNDER 18 YEARS OF AGE)		
Parent's Name		
Parent's Address		City:
Parent's State/Zip		
Parent's Cell Phone		Addl Phone:
PREFERRED PHARMACY		
Pharmacy Name:		
Pharmacy Address/ Phone Number:		
INSURANCE INFORMATION		
Insurance Co Name		
Policy No		GROUP:
FINANCIAL RESPONSIBLE PARTY (Guarantor for Insurance)		
Card Holder Name		DOB
SSN		
Address		
City		State/Zip
Phone		Cell Phone
Relationship /Patient	Spouse Child of Card Holder	
SECONDARY INSURANCE		
Insurance Co Name		
Policy		Group No
Guarantor Name		Date of Birth
EMERGENCY CONTACT		
Name		Cell Phone
PRIMARY PHYSICIAN INFORMATION		
Provider Name & Practice Name		
Address/Phone/Fax		

MEDICATIONS

Please list all prescribed medications.

Medication	Dose	How often	Prescribing Provider	Reason

HEALTH HISTORY

Have you been diagnosed with any of the following:

	Diabetes		Asthma		Anxiety
	Hypothyroidism		Osteoporosis		Bipolar
	High Blood Pressure		COPD		Cancer
	High Cholesterol		Asthma		Kidney disease
	Stroke		Lupus		Liver disease (Hepatitis)
	Heart attack		Migraines		
	Heart Arrhythmia (Afib)		Seizures		
	Blood clots (Leg, Arm, Lung)		Depression		

DO YOU HAVE ANY **ALLERGIES TO ANY MEDICATION**? IF YES, WHICH MEDICATION?

MEDICATION REACTION

DO YOU HAVE ANY ALLERGIES _____

SURGICAL HISTORY ☐ I Have Never Had Surgery

Date	Details

GYN SURGERY

Have You Ever Had An Ovary Removed? ☐ No ☐ Yes Left Right Both	☐ Hysterectomy Year:_____ Reason:_____ Type: Abdominal Vaginal Laparoscopic
☐ Endometrial/Uterine Ablation Year: _____	☐ Tubal Sterilization Year: _____
☐ Breast Biopsy Year: _____ Result _____ _	

FAMILY HISTORY

☐ I WAS ADOPTED

Family Member	Alive/Deceased	Age/Age at death	Illness
Father			Diabetes Heart Disease High Cholesterol Cancer : Type_____ Hypertension Stroke
Mother			Diabetes Heart Disease High Cholesterol Cancer : Type_____ Hypertension Stroke
Siblings			Diabetes Heart Disease High Cholesterol Cancer : Type_____ Hypertension Stroke
Children			Diabetes Heart Disease High Cholesterol Cancer : Type_____ Hypertension Stroke

SOCIAL HISTORY

Occupation:	Employer :
Marital Status ☐ M ☐ S ☐ D ☐ W Partner	Are You Sexually Active? ☐ Yes ☐ No ☐ Men ☐ Women ☐ Both ☐ Previously Not Now
Past/Current Partner Violent ☐ Yes ☐ No	Drink Caffeine ☐ Yes ☐ No How Many Servings Daily?
Drink Alcohol ☐ Yes ☐ No ☐ Former How Many Drinks/Per Week	Do You Exercise ☐ Yes ☐ No
Do You Smoke ☐ No ☐ Current Smoker How Many Cig/Day_____ For _____ Years	☐ Former Smoker How Many Cig/Day_____ For _____ Years
Have You Used Any In The Last Year? ☐ Marijuana ☐ Cocaine ☐ Heroin ☐ Other	Do You Use Any Other Substances? ☐ Yes ☐ No If Yes, What Type _____

HEALTH SCREENINGS

Have you ever had a Bone Density/DEXA? ☐ Yes ☐ No

Month/Year of last Bone Density/DEXA? _____Result ☐ Normal ☐ Abnormal

If abnormal, please explain: _____

Have you ever had a colonoscopy? ☐ Yes ☐ No

Month/Year of last colonoscopy? _____Result ☐ Normal ☐ Abnormal

If abnormal, please explain:_____

Have you ever had a Cholesterol test? ☐ Yes ☐ No

Have you ever been tested for diabetes? ☐ YES ☐ NO

Month/year of last Diabetes test? _____Result ☐ Normal ☐ Abnormal

If abnormal, please explain _____

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MENSTRUAL & ANNUAL EXAM HISTORY

Age Of First Menstrual Period	Do You Currently Have Menstrual Periods? ☐ Yes Date Of The First Day Of Your Last Period? _____ ☐ No What Year Was Your Last Period? _____
Are Your Periods Regular? ☐ Yes ☐ No If No, Please Explain:	☐ Never Had An Annual Exam Month/Day/Year Of Last Annual Exam: _____ Result ☐ Normal ☐ Abnormal
Have You Ever Had Abnormal Pap? ☐ Yes ☐ No In What Year_____ List Treatment (If Any) _____	
☐ Never Had A Mammogram Date Of Last Mammogram _____Result ☐ Normal ☐ Abnormal If Abnormal, Please Explain _____ Do You Perform Self Exams? ☐ Yes ☐ No	
Number Pregnancies	Total Living Children
# Of Full Term Deliveries	# Of Abortions
# Of Miscarriages	# Of Etopic Pregnancies
Number Of C-Sections	

How did you hear about us? _____

ANNUAL EXAM INFORMATION

MAY RESULT IN A CO-PAY OR ADDITIONAL CHARGES

- A preventive annual exam covers specific services. Any additional services performed today may be deemed by your insurance company as additional and your insurance company may decide this annual exam visit is charged a co-pay. In that instance you will be billed the co-pay once we hear back from your insurance company. You understand you may be billed for this portion of the exam and accept responsibility for this expense.
- If you have had an annual exam within the last 365 days, your insurance company will most likely not pay for today's visit. It is the patient's responsibility to make sure today's visit will be covered by their insurance company. If the exam is not covered, the expense will be the responsibility of the patient.
- **Please be advised that not all insurance policies cover preventive women's health exams. Some insurance companies require a waiting period after the effective date for preventive exams.**

Signature of Patient/Patient Representative

_____ Date _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE & CONSENT TO USE & DISCLOSE HEALTH INFORMATION

This acknowledgement of notice and consent authorizes Vitality Health to use and disclose health information about you for treatment, payment, and health care operations purposes. Notice of Privacy Practices: Vitality Health has a Notice of Privacy Practices, which describes how we may use and disclose your protected health information and how you can access your protected health information and exercise other rights concerning your protected health information. You may review our current notice prior to signing this acknowledgement and consent. We reserve the right to change our Notice of Privacy Practices and to make the terms of any change effective for all protected health information that we maintain, including information created or obtained prior to the date of the effective date of the change.

Acknowledgement and Consent: I have received the Notice of Privacy Practices for Vitality Health. Vitality Health is authorized to use and disclose health information about me to (i.e., spouse, parent, primary physician):

Signature of Patient/Patient Representative

X_____ Date _____

MEDICARE PATIENTS

I request that payment of authorized Medicare and/or insurer benefits be made to me or on my behalf to Vitality Health for services furnished to me by said provider. I authorize to release to my insurance company any medical information needed to determine the benefits or benefits payable to related services. I understand that if, under my insurance guidelines, a necessary service is determined to be non-covered, I will personally be responsible for payment. I understand I am financially responsible for any amount denied or partially paid by the Third Party Insurance Carrier. I authorize the release of medical information for treatment, payment, and healthcare operations.

Signature of Patient/Patient Representative

X_____ Date _____

COMMUNICATIONS & MESSAGES

LEAVING MESSAGES

I authorize messages, to include all lab/imaging results and appointment reminders be left at this phone number: Please make sure your voicemail is available so that we can contact you.

PHONE NUMBER: _____

SENDING TEXT MESSAGES

I authorize messages, to include all lab/imaging results and appointment reminders and office announcements be **sent via text** at this cell phone number:

CELL PHONE NUMBER: _____

Signature of Patient/Patient Representative

_____ Date _____

ADDITIONAL AUTHORIZATION IS REQUIRED BY YOUR INSURANCE COMPANY

I understand that if my insurance doesn't approve of any medications or procedures recommended by the provider, that additional effort and paperwork for prior authorization will be required by myself and by the office staff. This may require the patient to be the point of contact for the transaction for additional information. This effort can take up to 10 business days to put into action. Please make sure your voicemail is available so that we can contact you.

Signature of Patient/Patient Representative

_____ Date _____

PRESCRIPTION REFILLS

Please allow 5-7 business days to refill any current prescription **that does not require** prior authorization.

Signature of Patient/Patient Representative

_____ Date _____

PAYMENT POLICY

Payment of all co-pays is due at the time of service. As a service to you, our office will bill your insurance company. Being a participating provider with most insurance companies, the insurance companies require that we collect these fees, as they are terms of your health care contract. Additionally, patients are ultimately responsible for all balances. For your convenience, we accept credit cards including Visa, MasterCard, American Express, and Debit Cards. Due to the constant changes in health insurance, it is your responsibility to know your health coverage. If you should have any questions regarding if a certain procedure is covered, it is to your advantage to call your insurance company and find out exactly what your contract covers. Their customer service representatives will be happy to assist you. Our mission is to provide you with the highest quality gynecological care possible. We are constantly trying to control our costs while conforming to the standard fee schedules approved by most major insurance companies. Our receptionist will need to verify your insurance coverage prior to every visit.

1. Your medical insurance card and personal identification must be presented to the receptionist at each visit.

2. Any outstanding balances are required be paid before your office visit or procedure unless prior payment arrangements have been made. Outstanding balances may result in discharge from the practice.

3. Your insurance is a contract between you and the insurance company. While we accept the reimbursement rates of many insurance companies, we are not a party to your contract and do not determine which are medically necessary services that they cover and which they do not.

4. Our relationship and treatment responsibility are with/to you. We will attempt to notify you whenever we know a test or service is not covered. There will, however, there may be times when we cannot determine this. Whether covered or not, you are ultimately responsible for payment of the services received.

5. We require payment in full on the date of service for co-pay and office charges defined under your policy as your responsibility.

6. We expect you to call us if you are not able to make it to your appointment. For your convenience, we make every attempt to remind you of your appointment. Your appointment is a reservation of the offices', staff and doctor's time and resources. A charge of $50 for office visits will be made for appointments that are not canceled 24 hours in advance. A charge of $150 for any canceled or no-show surgical procedure.

We realize that on occasion, temporary financial problems may affect the timely payment of your account. If such problems arise, we encourage you to contact us promptly for assistance. I have read and understand the terms listed above.

X_____ Date _____

Signature of Patient/Patient Representative