



Paula E. Orr, M.D.  
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5319 Parkshire Way  
North Charleston, S.C 29418  
(843) 767-2121  
Fax: (843) 767-2102

## Welcome to Charleston Women's Wellness Center!

To help us provide you with superior healthcare you deserve, previous medical records are required. Please be sure to contact your last physician to obtain last pap results, any blood work, mammogram reports, surgery reports, prenatal notes, etc. these can be faxed to us at (843) 767-2102, Attn: Medical Records, or you may bring them with you on your appointment date.

If we do not have your records in the office by your appointment time, it may result in canceling or rescheduling your appointment. Thank you for your cooperation.

Sincerely,

*Charleston Women's Wellness Center Staff*



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## PATIENT REGISTRATION

Name \_\_\_\_\_ SS# \_\_\_\_\_  
Street Address \_\_\_\_\_ Date of Birth \_\_\_\_\_ Martial Status: S M W Sep D  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Telephone: Home \_\_\_\_\_ Office \_\_\_\_\_ Cell \_\_\_\_\_  
Email \_\_\_\_\_  I would like to receive email messages.  
Referred by \_\_\_\_\_  
Spouse's Name \_\_\_\_\_  
Spouse's Employer / Address \_\_\_\_\_  
Emergency Contact \_\_\_\_\_ Telephone \_\_\_\_\_ Relationship \_\_\_\_\_

## PATIENT EMPLOYER INFORMATION

Employer Name \_\_\_\_\_ Telephone \_\_\_\_\_  
Employer Street Address \_\_\_\_\_ City / State \_\_\_\_\_ Zip \_\_\_\_\_  
Patient's Occupation \_\_\_\_\_

## INSURED PERSON (IF NOT PATIENT)

Name \_\_\_\_\_ Telephone \_\_\_\_\_  
Street Address \_\_\_\_\_ City / State \_\_\_\_\_ Zip \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_

## INSURANCE

Insured's Date of Birth \_\_\_\_\_ Insured's SS# \_\_\_\_\_  
Medicaid # (if applicable) \_\_\_\_\_ Medicare # (if applicable) \_\_\_\_\_  
Primary Insurance Company Name \_\_\_\_\_  
ID # \_\_\_\_\_ Group # \_\_\_\_\_ Telephone \_\_\_\_\_  
Secondary Insurance Company Name \_\_\_\_\_  
ID # \_\_\_\_\_ Group # \_\_\_\_\_ Telephone \_\_\_\_\_

## INFORMATION & ASSIGNMENT OF BENEFITS

I hereby authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

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

I hereby authorize CHARLESTON WOMEN'S WELLNESS CENTER to apply for benefits on my behalf for covered services by him/her or by his/her order. I request that payment from my insurance company be made directly to CHARLESTON WOMEN'S WELLNESS CENTER (or to party who accepts assignment).

I certify that the information I have reported with regard to my insurance coverage is correct.

I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

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



## **Welcome to Charleston Women's Wellness Center!**

We are excited that you have chosen us as your OB/GYN caregiver and we look forward to meeting your needs

Please complete all of your health information as thoroughly as you can to allow us to better serve you.

Each patient is unique and has her own special healthcare needs. At Charleston Women's Wellness Center, we believe that good health is not just about physical health, but emotional and spiritual health as well. That's why we are pleased to offer additional services that we think are vital to the health and well-being of all women. We are pleased to offer our own unique line of vitamins and supplements that are designed for the specific needs of women no matter where you are in your life cycle. Additionally we are happy to have our own skin care line that is completely botanically formulated with each woman's unique skin care needs. Be sure to ask about these products and whether they would be right for you.

We feature a safe medically managed weight loss program involving our own nutritionist with appropriate referrals to a personal trainer to further assist in meeting your weight loss goals.

We are also pleased to offer massage therapy as a part of our integrative medicine approach to wellness.

We hope that you will find our services useful to your overall health and wellness goals. We look forward to meeting you soon.

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[www.charlestonwomenswellnesscenter.com](http://www.charlestonwomenswellnesscenter.com)



## ACKNOWLEDGEMENT OF PRIVACY PRACTICES POLICY FOR CHARLESTON WOMEN'S WELLNESS CENTER

**This notice describes how medical information about you may be used and disclosed and how you can get access to this information.** Please review it carefully. This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes our rights to access and control your protected health information.

**We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notices at any time.**

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of the physician's practice. We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health related benefits and services that may be of interest to you. We may also use and disclose you protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you.

**Others involved in your healthcare.** Unless you previously authorize, we will not disclose any of your private information to any member of your family, any close friend, or any other person requesting your information.

**The following are situations that are permitted and required uses and disclosures that may be made without your authorization or opportunity to object:** required by law, public health, communicable diseases, health oversight, abuse or neglect, food and drug administration, legal proceedings, law enforcement, coroners, funeral directors, and organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, required uses and disclosures.

**You have the right to inspect and request a copy of your protected health information.** Depending on the circumstances, a decision to deny this access may be reviewed.

**You have the right to request restriction of your protected health information.** This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment, or health care operations. You may also request that any part of your protected health information not be disclosed to any family members or friend who may be involved in your care or for the notification purposes described in this Notice of Privacy Practices. Your request must state the specific restriction request and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. With this in mind, please discuss any restriction you wish to request with your physician.

**Complaints.** You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact, the office manager, of your complaint. We will not retaliate against you for filing a complaint.

**By signing you agree to the terms and conditions listed above.**

**Print Patient Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_

**Staff Initials:** \_\_\_\_\_



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**Financial Agreement**

Payment is to be paid in full at time of service. Your financial portion will be collected upfront. We will not guarantee retro-active coverage and will collect payment in full at time of service. You may be charged a billing fee of \$10.00 if deductible or co-pay is not paid at the time of service.

The providers are here to provide you the best possible medical care; therefore, they will not field any questions concerning financial obligations. Any such questions should be directed to our insurance billing specialist, Irving Industries at (843) 851-1355 and/or the office manager of Charleston Women's Wellness Center.

Insurance is filed as a courtesy and not an obligation. Any remaining balances after insurance has reported, are to be paid within thirty (30) days of notification to the patient. All balances are the sole responsibility of the patient, or the parent/guardian of the minor patient. It is the responsibility of the patient and the insurer to be knowledgeable of your own insurance policy. Including covered services, deductible information, co-pays and pre-existing clauses. Any problems of non-payment from the insurance companies will become the immediate responsibility of the patient and all accounts must be settled with thirty (30) days of notification, unless payment arrangements have been made between the patient and our insurance billing specialist, Irving Industries. We will provide information and documentation to the patient to help them negotiate with their insurance carrier.

Patients with no insurance or proof of insurance on the date of service will be considered self-pay. Self-pay patients will sign this form indicating that they have **NO** health insurance and will be responsible for the total balance on the date of service. However, this discount does not apply to medications, shots or labs. It applies only to office visits and procedures.

**\*Co-pays, balances due and patients' financial portions for services provided will be collected upon check-in on date of service.**

In all cases, insured or self-pay, collections notices will begin if the patient owed balance is not received within 90 days of notification to the patient. All unpaid balances will be sent to an outside agency after all efforts have been exhausted. this may result in your dismissal from the practice. The patient will be responsible for all collection cost to include court fees and attorney fees should the practice have to pursue delinquent accounts in small claims court.

By signing below, you accept the terms stated above and allow us to file your insurance and accept assignment of your insurance benefits. In the event that your insurance company requests copies of your records for benefit determination, you authorize us to provide any and all information to them necessary for maximum benefits.

**I \_\_\_\_\_ (have/do not have) health insurance coverage, have read, understand and agree to accept the terms and conditions stated above.**

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Responsible Party Signature  
(If not patient being seen)

\_\_\_\_\_  
Relationship to patient

\_\_\_\_\_  
(Account #)

\_\_\_\_\_  
Staff Initials



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## PATIENT QUESTIONNAIRE

REASON FOR VISIT \_\_\_\_\_

PAST MEDICAL & FAMILY HISTORY Please check (✓) if you (SELF) or any blood relative (FAM) had any of the following conditions.

	SELF	FAM		SELF	FAM
1. HEADACHES / MIGRAINE	<input type="checkbox"/>	<input type="checkbox"/>	15. BLOOD TRANSFUSIONS	<input type="checkbox"/>	<input type="checkbox"/>
2. HEART / VASCULAR DISEASE RHEUMATIC DIS	<input type="checkbox"/>	<input type="checkbox"/>	16. ANEMIA / BLOOD DISORDER	<input type="checkbox"/>	<input type="checkbox"/>
3. HIGH BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	17. VARICOSE VEINS / PHLEBITIS	<input type="checkbox"/>	<input type="checkbox"/>
4. HIGH CHOLESTEROL	<input type="checkbox"/>	<input type="checkbox"/>	18. SKIN DISEASE	<input type="checkbox"/>	<input type="checkbox"/>
5. RESPIRATORY DISEASE PULMONARY (LUNG)	<input type="checkbox"/>	<input type="checkbox"/>	19. DIABETES	<input type="checkbox"/>	<input type="checkbox"/>
6. BREAST DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	20. THYROID DISEASE	<input type="checkbox"/>	<input type="checkbox"/>
7. JAUNDICE / HEPATITIS	<input type="checkbox"/>	<input type="checkbox"/>	21. CANCER (TYPE)	<input type="checkbox"/>	<input type="checkbox"/>
9. HIATAL HERNIA (REFLUX)	<input type="checkbox"/>	<input type="checkbox"/>	(TYPE)	<input type="checkbox"/>	<input type="checkbox"/>
10. PEPTIC ULCER (STOMACH)	<input type="checkbox"/>	<input type="checkbox"/>	22. EPILEPSY / NEUROLOGICAL DIS.	<input type="checkbox"/>	<input type="checkbox"/>
11. BOWEL DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	23. ARTHRITIS - JOINT PAIN	<input type="checkbox"/>	<input type="checkbox"/>
12. KIDNEY DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	24. OSTEOPOROSIS	<input type="checkbox"/>	<input type="checkbox"/>
13. URINARY INCONTINENCE	<input type="checkbox"/>	<input type="checkbox"/>	(FRAGILE BONES)	<input type="checkbox"/>	<input type="checkbox"/>
14. URINARY INFECTIONS	<input type="checkbox"/>	<input type="checkbox"/>	25. ANXIETY / DEPRESSION	<input type="checkbox"/>	<input type="checkbox"/>
			26. SLEEP PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>

HOSPITAL ADMISSIONS List those operations & serious illness which required hospitalization (excluding pregnancy)

YEAR	REASON FOR ADMISSION / HOSPITALIZATION	YEAR	REASON FOR ADMISSION / HOSPITALIZATION

MEDICATIONS List all medications you are currently taking (dosage-frequency) - include over the counter drugs, vitamins and herbal medications.

		Drug Allergies

### DIET

How would you describe your diet? \_\_\_\_\_  
 Would you like to see a nutritionist? \_\_\_\_\_

### EXERCISE

Do you exercise? \_\_\_\_\_ Regularly \_\_\_\_\_ Occasionally \_\_\_\_\_ Not at all. What type of exercise do you participate in? \_\_\_\_\_  
 Do you have issues you would like to address regarding exercise or an exercise program? \_\_\_\_\_

MENSTRUAL HISTORY Age at first period? \_\_\_\_\_ If Menstruating - date of last period (1st day) \_\_\_\_\_

Period Interval (1st day to 1st day)	Number of days?	Duration of Bleeding?	Cramps?	Y	N	Mild	Severe	Mod.	Always Present	Medications for cramps?	Y	N
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>

How many periods in the last year? \_\_\_\_\_ Bleeding (spotting) between periods? Y N

VAGINAL INFECTIONS - History of  YEAST  TRICHOMONAS  CHLAMYDIA  HERPES  GONORRHEA  BACTERIAL VAGINOSIS

PAP TEST Date of last test \_\_\_\_\_  NORMAL  ABNORMAL MAMMOGRAM Date of last test \_\_\_\_\_  NORMAL  ABNORMAL

CONTRACEPTIVE HISTORY Current Method \_\_\_\_\_ IF PILL - BRAND \_\_\_\_\_ PAST METHODS \_\_\_\_\_

### OBSTETRICAL

HISTORY -Number of PREGNANCIES _____					PREMATURE BABIES _____					MISCARRIAGES _____					ABORTIONS _____					LIVING CHILDREN _____															
BORN YEARS / MOS.	WEEKS PREG.	WT.	SEX	TYPE OF DELIVERY	REMARKS	BORN YEARS / MOS.	WEEKS PREG.	WT.	SEX	TYPE OF DELIVERY	REMARKS	BORN YEARS / MOS.	WEEKS PREG.	WT.	SEX	TYPE OF DELIVERY	REMARKS	BORN YEARS / MOS.	WEEKS PREG.	WT.	SEX	TYPE OF DELIVERY	REMARKS												
1.						4.						2.						5.						3.						6.					
2.						5.						3.						6.																	
3.						6.																													

MENSTRUAL HISTORY If applicable - HOT FLASHES Y N TREATMENT \_\_\_\_\_

SEXUAL HISTORY  SATISFACTORY  UNCOMFORTABLE  WISH TO DISCUSS \_\_\_\_\_

SOCIAL HISTORY Smoking - Cig./Day \_\_\_\_\_ # Years \_\_\_\_\_ Alcohol - Oz./Week \_\_\_\_\_ Coffee - Cups/Day \_\_\_\_\_ Street Drugs \_\_\_\_\_