AFFINITY WOMEN'S HEALTH, LLC **STANLEY WIERCINSKI D.O.**

Today's Date:	Last Name:	First Name:	MI:	Email :

Street Address:	City:	State:	Zip Code:

Marital Status:	Social Security #:	Date of Birth:	Age:	Occupation:

Home Phone:	Cell Phone:	Work Phone:	Employer:

Responsible Party:	Date of Birth:	Social Security #:
		- -

Home #	Work #	Cell #	Relationship to Patient:

Address:		Employer:
City/State/Zip:		

Emergency Contact:		Relationship to Patient:
Phone: Home #	Work #	Cell #

Subscriber Name: (Insurance)	DOB:	SSN:	Relationship:

Phone: Home#:	Work #:	Cell #
Address:		Employer:
City/State/Zip:		

Please initial and sign at the bottom:

_____ Authorization and Assignment of Benefits: I hereby give permission to Affinity Women's Health and its employees, agents, and medical providers to release medical information to health plans, health organizations, governmental agencies, and other entities charged with fiscal responsibility for the payment of medical services rendered to me. I hereby authorize payment of the medical benefits otherwise payable to me to be directed to Affinity Women's Health. I consent to have any monies received by the provider of services on my behalf to be applied to my outstanding accounts. I assume full responsibility for payment of any charges for the medical services provided. I understand that any or all of my medical information may be electronically submitted to any or all treating providers, hospitals, and/or health care entities. I permit a copy of this authorization to be used in place of the original.

_____ Financial Policy Acknowledgement: I hereby acknowledge that I have received and reviewed the FINANCIAL POLICY of Affinity Women's Health. I understand that it is my responsibility to provide Affinity Women's Health with my current demographic, insurance, and medical information.

_____ HIPAA Privacy Acknowledgement: I hereby acknowledge that I have received and reviewed the NOTICE OF THE PRIVACY PRACTICES from Affinity Women's Health, LLC.

Patient or Guardian Signature:_____ Relationship: _____ Date: _____

AFFINITY WOMEN'S HEALTH, LLC **STANLEY WIERCINSKI D.O.**

1010 N Bancroft Parkway, LL3 Wilm. De. 19805 121 Becks Woods Drive, Ste 100 Bear, De. 19701

Patient Consent for Use and Disclosure of Protected Health Information

The individual whose signature appears below hereby attests to the following statements:

With my consent, Affinity Women's Health LLC, may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (Please refer to Affinity Women's Health LLC'S Notice of Privacy Practices for a more complete description of such uses and disclosures.)

With my consent, Affinity Women's Health, may disclose my PHI to the following individuals (family, relatives, or friends) who may assist in my care:

Name	Relationship	Home #:	Work #:	Cell #:

Please indicate name, contact numbers, and relationship of individuals to whom Affinity Women's Health may release PHI.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Affinity Women's Health reserves the right to revise its Notice of Privacy Practices at any time. A written copy of our Notice of Privacy Practices may be obtained by forwarding a written request to our office.

CONSENT FOR CALLS TO HOME
With my consent, Affinity Women's Health may call my home or other designated location and leave message on my voice mail or with a person in reference to any item that may assist Affinity Women's Health in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results, among others.

CONSENT FOR MAIL
With my consent, Affinity Women's Health may mail to my home or other designated location any item that may assist Affinity Women's Health in carrying out TPO such as appointment reminder cards and patient statement as long as they are marked CONFIDENTIAL.

CONSENT FOR E-MAIL
With my consent, Affinity Women's Health may e-mail to my designated e-mail address any message in reference to any item that may assist in my care.

Affinity Women's Health may contact me for TPO use, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results, among others.

I have the right to request that Affinity Women's Health restricts how it uses or discloses my PHI to carry out the TPO, However, Affinity Women's Health is not required to agree to my requested restrictions, but, if it does, it is bound by this agreement.

By signing this form, I am consenting to Affinity Women's Health use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that Affinity Women's Health has already made disclosure in reliance upon my prior consent. If I do not sign this consent, Affinity Women's Health may decline to provide services to me.

Signed by: _____ _____
Signature of Patient or Legal Guardian Relationship to Patient

_____ _____
Patient's Name Date

_____
Printed Name of Patient or Legal Guardian

(PATIENT/GUARDIAN WILL BE PROVIDED WITH A SIGNED COPY OF THIS AUTHORIZATION)

OFFICE POLICIES & FEE'S

COPAY DUE AT THE TIME OF VISIT, EACH VISIT REQUIRES COPAY AS PER YOUR INSURANCE

PAST DUE BALANCES MUST BE PAID PRIOR TO VISIT

BRING INSURANCE CARD TO EACH VISIT

AFTER 3 NO SHOW APPOINTMENTS, WILL BE DISMISSED FROM PRACTICE

$25 NO SHOW FEE IF APPOINTMENT NOT CANCELLED WITHIN 24HRS PRIOR

$40 CANCELLATION FEE FOR SURGERY (if cancelled any time after surgery date is given)

$10 FMLA/DISABILITY FORM FEE (per form to be completed)

$35 BOUNCED CHECK FEE

NO CHARGE FOR MEDICAL RECORDS IF TRANSFER PHYSICIAN TO PHYSICIAN, IF COPY FOR SELF FEE CHARGED AS FOLLOWS:

$2.00 per page for pages 1-10

$1.00 per page for pages 11-20

$0.90 per page for pages 21-60

$0.50 per page for pages 61+

I hereby acknowledge that I have reviewed and understand the policies, furthermore by signing I agree to comply with fee's and policies.

_____ _____

Patient Signature **Date**

_____ _____

Office Staff/Witness **Date**

AFFINITY WOMEN'S HEALTH, LLC **STANLEY WIERCINSKI D.O.**

PATIENT NAME: _____ **DATE OF BIRTH:** _____

MEDICAL HISTORY	*PLEASE CIRCLE*	*YEAR DIAGNOSED*
1. ASTHMA	**CURRENT / PAST**	_____
2. BREAST CANCER	**CURRENT / PAST**	_____
3. DEEP VAIN THROMBOSIS	**CURRENT / PAST**	_____
4. DEPRESSION	**CURRENT / PAST**	_____
5. DIABETES MELLITUS	**CURRENT / PAST**	_____
6. EPILEPSY	**CURRENT / PAST**	_____
7. HEPATITS (*SPECIFY TYPE)* _____	**CURRENT / PAST**	_____
8. HUMAN IMMUNODEFICIENCY VIRUS (HIV)	**CURRENT / PAST**	_____
9. ELEVATED CHOLESTEROL	**CURRENT / PAST**	_____
10. HYPERTENSION (HIGH BLOOD PRESSURE)	**CURRENT / PAST**	_____
11. HYPERTHYROIDISM/HYPOTHYROIDISM (*CIRCLE TYPE*)	**CURRENT / PAST**	_____
12. MITRAL VALVE PROLAPSE	**CURRENT / PAST**	_____
13. OSTEOPENIA/OSTEOPOROSIS (*CIRCLE* *TYPE*)	**CURRENT / PAST**	_____
14. PULMONARY EMBOLISM	**CURRENT / PAST**	_____
15. PREVIOUS BLOOD TRANSFUSION (*SPECIFY WHEN/WHY*) _____		
16. OTHER _____		

SURGICAL HISTORY	***MONTH/YEAR***
LIST: _____	_____
_____	_____
_____	_____
_____	_____

ALLERGIES TO MEDICATIONS:	***REACTIONS***
LIST: _____	_____
_____	_____

CURRENT MEDICATIONS:

_____

_____

PHARMACY NAME:	***ADDRESS OR PHONE #:***
_____	_____

AFFINITY WOMEN'S HEALTH, LLC **STANLEY WIERCINSKI D.O.**

PATIENT NAME: _____ **DATE OF BIRTH:** _____

WHO REFERED YOU TO THIS PRACTICE? PATIENT / ONLINE / INSURANCE / ANOTHER DR (*NAME*) _____

GYNECOLOGIC HISTORY

HISTORY OF ABNORMAL PAP	**YES / NO**	**YEAR:** _____
ENDOMETRIOSIS	**YES / NO**	**YEAR:** _____
SEXUALLY TRANSMITTED DISEASE (*specify*) **(CHLAMYDIA, GONORRHEA, HERPES ORAL/GENITAL, TRICHOMONAS, SYPHILLIS, HPV)**	**YES / NO**	**YEAR:** _____
PELVIC INFLAMMATORY DISEASE	**YES / NO**	**YEAR:** _____

LAST PAP SMEAR	**MONTH/YEAR** _____	**COLONOSCOPY**	**MONTH/YEAR** _____
MAMMOGRAM	**MONTH/YEAR** _____	**DEXA/BONE DENSITY SCAN**	**MONTH/YEAR** _____

MENSTRAUL HISTORY	***PREGNANCY HISTORY***
LAST MENSTRAUL PERIOD: _____	**TOTAL # OF PREGNANCIES:** _____
BIRTH CONTROL METHOD: _____	**# FULL TERM** _____ **# PRETERM** _____
MENOPAUSE YES / NO WHAT AGE? _____	**# MISCARRIAGES** _____ **# ABORTIONS** _____

TYPE OF DELIVERIE(S) VAGINAL / C-SECTION **BABY'S WEIGHT** **DATE**

_____

_____

_____

COMPLICATIONS DURING PREGNANCY: _____

SOCIAL HISTORY

Do You Smoke **CURRENT / PAST / NEVER (*please circle*)**

_____ PER DAY X _____ YEARS

Drink Alcohol **DAILY / WEEKLY / OCCASIONALLY / NEVER (*please circle*)**

Drug Use **CURRENT / PAST / NEVER (*please circle*)**

TYPE: _____

FAMILY HISTORY	**RELATIVE/AGE**		**RELATIVE/AGE**
BREAST CANCER	**YES / NO** _____	**OSTEOPOROSIS**	**YES / NO** _____
COLON CANCER	**YES / NO** _____	**OVARIAN CANCER**	**YES / NO** _____
DIABETES	**YES / NO** _____	**STROKE**	**YES / NO** _____
HEART DISEASE	**YES / NO** _____	**THYROID DISEASE**	**YES / NO** _____
HIGH BLOOD PRESSURE	**YES / NO** _____	**OTHER:** _____	

IQHealth

Welcome to Your Secure Patient Portal!

Dear Patient,

We are excited to offer you a new informational system through United Medical Physicians called **IQHealth**. This system allows web based interactions between patients and our office. You will be able to:

View your test results
Request an appointment
Request medication refills
Update demographic information
Send and receive messages
Keep track of your health

In order to take advantage of this new feature, we will need your email address. You will then receive a one-time secure email invitation from **IQHealth.com** to set up an account. Simply click on the link in your email and follow the prompts to activate your account. For any questions or concerns please contact the office for assistance.

We hope this new system will make communication with our office easier and more convenient. If you choose not to participate, you may still contact the office via telephone and mail.

Sincerely,

Affinity Women's Health

I wish to participate

Name: _____

Email Address: _____

Last 4 digits of SSN: _____

I do not wish to participate

Name: _____