INSTRUCTIONS FOR PDF FILLABLE FORMS

FOR PATIENTS

Please download the file prior to filling in the form online.

Upload the completed document to us via the upload button as it will email securely to our INBOX.

Thank you!

ESSENTIAL WOMAN, LLC

Received and completed by _____

PATIENT INFORMATION

Title	Sex	Date of Birth
☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Jr ☐ Sr ☐ II ☐ I	☐ Female ☐ Male	mm / dd / yyyy

First Name	Middle Initial	Last Name	Social Security Number
			- -

Physical Address	City	State	Zip

Mailing Address	City	State	Zip

Preferred Phone Number	Home Phone Number	Cell Phone Number	Work Phone Number
( ) -	( ) -	( ) -	( ) -

Email Address	Confidential Communication Preference
	☐ Email ☐ Letter ☐ Other _____ ☐ Patient Portal

Marital Status
☐ Single ☐ Married ☐ Divorced ☐ Legally Separated ☐ Widowed ☐ Unknown

Preferred Language	Ethnicity
	☐ Hispanic or Latino ☐ NOT Hispanic or Latino ☐ Unknown

Race
☐ American Indian ☐ Asian ☐ Black /African American ☐ Native Hawaiian ☐ Other Pacifica Islander ☐ White ☐ Other

Employer Name

PARENT / LEGAL GUARDIAN / LEGAL REPRESENTATIVE INFORMATION

Title	Sex	Date of Birth
☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Jr ☐ Sr ☐ II	☐ Female ☐ Male	mm / dd / yyyy

First Name	Middle Initial	Last Name	Social Security Number
			- -

Address	City	State	Zip	Email Address

Relation to Patient	Home Phone Number	Cell Phone Number	Work Phone Number
	( ) -	( ) -	( ) -

PRIMARY INSURANCE

Insurance Carrier Name		
Group Name	Group Number	
Subscriber Name		
Subscriber ID		
Subscriber Date of Birth	Relation to Patient	

Employment Status
☐ Employed ☐ Unemployed ☐ Retired ☐ Student

SECONDARY INSURANCE

Insurance Carrier Name		
Group Name	Group Number	
Subscriber Name		
Subscriber ID		
Subscriber Date of Birth	Relation to Patient	

Employment Status
☐ Employed ☐ Unemployed ☐ Retired ☐ Student

SPOUSE OR EMERGENCY CONTACT

First Name	Last Name	Relation to Patient

Home Phone Number	Cell Phone Number

REFERRAL

How did you hear about our clinic?

Referred by

SIGNATURE

Signature of Patient or Legal Guardian	Date
	mm / dd / yyyy

Patient Account # _____

PATIENT HEALTH INFORMATION

First Name	Middle Initial	Last Name	Date of Birth mm / dd / yyyy

Preferred Pharmacy	Pharmacy Location
Primary Care Physician	**Primary Care Physician Phone Number**

How would you describe your overall health	Smoking/Tobacco History	Alcohol Use	Drug Use	Caffeine use
☐ Excellent ☐ Good ☐ Fair	☐ Never ☐ Previous ☐ Current	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

ALLERGIES AND REACTIONS

Allergy	Describe Reaction	Allergy	Describe Reaction
Allergy	Describe Reaction	Allergy	Describe Reaction

CURRENT MEDICATIONS/HORMONES/SUPPLEMENTS/VITAMINS

Name	Dose / Strength	Frequency	Date Started

FEMALE HEALTH HISTORY

Age of first menstrual cycle	Duration of menstrual cycle	Frequency of menstrual cycle

Would YOU consider your cycle	Date of last period # of days	Date of last Mammogram	Date of last pap / annual exam
☐ Normal ☐ Abnormal			

Do you have, or have you ever had premenstrual syndrome (PMS) ?
☐ Yes ☐ No If YES, Please explain symptoms:

Contraception	History of contraception problems
☐ Birth control pills ☐ IUD ☐ Tubal ligation ☐ Vasectomy ☐ Other	☐ Yes ☐ No If YES, please explain:

OBSTETRICAL HISTORY

Please list the total number of each occurrence in the boxes below

Pregnancies	Full Term	Premature	Ectopic	Induced Abortions	Miscarriages	Multiple Births	Living Children

PREVIOUS HOSPITALIZATIONS OR SURGICAL PROCEDURES

Date / /	Date / /	Date / /	Date / /
Date / /	Date / /	Date / /	Date / /

FAMILY MEDICAL/CANCER HISTORY

Relation to patient ☐ Anemia	Relation to patient ☐ Fibrocystic Breast	Relation to patient ☐ Breast Cancer
Relation to patient ☐ Bleeding Disorder	Relation to patient ☐ Heart Disease	Relation to patient ☐ Ovarian Cancer
Relation to patient ☐ Diabetes	Relation to patient ☐ Hypertension	Relation to patient ☐ Uterine Cancer
Relation to patient ☐ Endocrine Problem	Relation to patient ☐ Osteoporosis	Relation to patient ☐ Other:

Patient Account # _____

First Name	Middle Initial	Last Name	Date of Birth
			mm / dd / yyyy

MEDICAL HISTORY DETAIL

(Please check all applicable symptoms that you have or have had)

- ☐ Abdominal pain
- ☐ Acne
- ☐ Altered sense of smell
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Ataxia
- ☐ Bells Palsy
- ☐ Black stools
- ☐ Bladder infections
- ☐ Bleeding tendency
- ☐ Blood clots
- ☐ Blood in mucus
- ☐ Blood in stool
- ☐ Blood in urine
- ☐ Blood transfusions
- ☐ Blurry vision
- ☐ Bowel problem
- ☐ Cancer
- ☐ Change in hair growth
- ☐ Change in skin color
- ☐ Chest pain – exerted
- ☐ Chest pain – resting
- ☐ Chills
- ☐ Cold hands or feet
- ☐ Constipation
- ☐ Coordination problems
- ☐ Coughing up of blood
- ☐ Depression
- ☐ Dermatitis
- ☐ Diabetes
- ☐ Diarrhea
- ☐ Dizziness
- ☐ Double vision
- ☐ Dry eyes
- ☐ Dry mouth
- ☐ Dry skin
- ☐ Dysphagia (difficulty swallowing)
- ☐ Ear pain
- ☐ Enlarged prostate
- ☐ Epilepsy
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Exercise intolerance
- ☐ Extremity weakness
- ☐ Eye disease (Glaucoma, etc)
- ☐ Eye pain
- ☐ Fatigue
- ☐ Fecal incontinence
- ☐ Fever
- ☐ Food allergies
- ☐ Fractures
- ☐ Gait disturbance
- ☐ Genital discharge
- ☐ Genital infections
- ☐ Goiters
- ☐ Hay fever
- ☐ Headaches / Migraines
- ☐ Hearing loss
- ☐ Heartburn
- ☐ Heart disease/Heart failure
- ☐ Heart problems
- ☐ Heavy bleeding
- ☐ Hemorrhoids
- ☐ Hepatitis
- ☐ Herpes genital/oral
- ☐ High blood pressure
- ☐ High cholesterol or lipids
- ☐ Hives
- ☐ Insomnia
- ☐ Intolerance to heat or cold
- ☐ Irregular periods
- ☐ Joint instability
- ☐ Joint pain
- ☐ Joint stiffness
- ☐ Joint swelling
- ☐ Kidney disease
- ☐ Kidney problems
- ☐ Liver disease
- ☐ Lung problems
- ☐ Lupus
- ☐ Lymph node enlargement
- ☐ Medication allergies
- ☐ Mouth pain
- ☐ Muscle pain (myalgias)
- ☐ Muscle weakness
- ☐ Nasal congestion
- ☐ Neck pain
- ☐ Night sweats
- ☐ Nervousness
- ☐ Numbness
- ☐ Ovarian problems
- ☐ Pain in feet or hands
- ☐ Pain with inhalation
- ☐ Pain with intercourse
- ☐ Palpitations
- ☐ Paresthesias (tingling/pricking)
- ☐ Post nasal drip
- ☐ Productive cough
- ☐ Rapid heart rate
- ☐ Rash
- ☐ Rectal bleeding
- ☐ Seasonal allergies
- ☐ Seizures
- ☐ Sever itching (pruitis)
- ☐ Shortness of breath
- ☐ Shingles
- ☐ Skin cancer
- ☐ Skin disease
- ☐ Skin lesions
- ☐ Skin nodules
- ☐ Skin ulcers
- ☐ Sore throat
- ☐ Speech disturbance
- ☐ Sprain
- ☐ Stomach problems
- ☐ Suicidal
- ☐ Syncope (fainting)
- ☐ Thyroid disease/ problems
- ☐ Tingling
- ☐ Tinnitus (ringing in ears)
- ☐ Trouble swallowing
- ☐ Ulcers
- ☐ Urinary incontinence
- ☐ Urinary frequency
- ☐ Venereal disease
- ☐ Visual acuity
- ☐ Visual changes
- ☐ Weight gain
- ☐ Weight loss
- ☐ Wheezing
- ☐ Yeast infections

Patient Account # _____

Patient First Name	Patient Last name

Parent / Guardian Name	Relation to Patient

NOTICE OF PRIVACY PRACTICES

My signature below indicates that I have been offered / provided with a copy of Essential Woman, LLC Notice of Privacy Practices.

PATIENT RIGHTS AND RESPONSIBILITIES

My signature below indicates that I have been offered / provided with a copy of Essential Woman, LLC patient rights and responsibilities.

DISCLOSURE OF OWNERSHIP INTEREST

My signature below indicates that I have been offered / provided with a copy of Essential Woman, LLC disclosure of ownership interest.

LABORATORY

My signature below indicates I understand that all lab work ordered by my physician and sent to an outside lab will be billed separately by that lab to my insurance company. I understand that I am responsible to pay for all lab charges, whether or not I have insurance and whether or not it is a covered benefit of my insurance. I understand that the laboratory will bill me separately for these lab charges.

FINANCIAL RESPONSIBILITY / ASSIGNMENT OF BENEFITS / BILLING AGREEMENT

Insurance is a way for you to receive repayment for fees you have paid to a physician for services rendered. Having insurance is not a substitute for payment. Even though insurance companies have a fixed allowance or percentage based on your policy with them, your policy is with your insurance company, not with this office. Please direct questions regarding your benefits to your insurance carrier or your human resources department. **Payment in full will be due at the time of service if a particular service is not covered, we are unable to verify coverage, your coverage is pending or you are ineligible for coverage.**

Payments on accounts billed are expected within 30 days of the statement date. **A $25.00 returned check fee will apply for every returned check that is received by our office.** Delinquent accounts will be charged interest at 2% per month. The undersigned specifically agrees to pay all reasonable attorneys' fees and court costs in the event legal action is taken to collect on an account. The undersigned further agrees to pay an additional amount representing up to 40% of the principal balance if the account is referred to a collection agency or attorney for collections. This additional amount is in recognition of the cost associated with the said collection action processing.

I hereby authorize the providers (s) of Essential Woman, LLC to release any information acquired in the course of my examination to my insurance company, another physician or hospital, adjuster or attorney. I authorize payment directly to Essential Woman, LLC for Aesthetic/Wellness/Procedures and/or medical benefits, if any, otherwise payable to me for services as described. I understand that I am responsible for all charges whether or not paid by my insurance company.

A photocopy of this assignment of benefits shall be considered as effective and valid as the original. I also authorize the physician to initiate a complaint to the insurance commissioner for any reason on my behalf. Any lab testing done in the office or outside laboratory will be billed separately by the laboratory. I consent to any medical treatment deemed medically necessary by the provider. I understand that these treatments will be discussed with me and all questions will be answered before it is rendered.

SIGNATURE

Signature of Patient or Legal Guardian	Date
	mm / dd / yyyy

Patient Account # _____

1405 SW 6th Avenue, Ocala, FL 34471. P: 352.421.5858

AUTHORIZATION TO USE OR DISCLOSE MEDICAL RECORDS

I give authorization to the provider listed below to disclose a copy of the specific health/medical information identified below:

NAME OF PATIENT		DOB	/ /	SS# last four:

TO: (Name, Address, Phone of **Recipient** of Records) (or as checked office location above)						
Name	Essential Woman LLC			Phone	**352-421-5858**	
Address	**1405 SW 6th Avenue**					
City/State Zip	City	**Ocala**	State	**FLORIDA**	Zip	34471

RECORDS FROM (Who is **Releasing** the Records):						
Name				Phone		
Address						
City/State Zip	City		State		Zip	

By Checking the Boxes Below, I Specifically Authorize the Use and/or Disclosure of the Following Health Information and/or Medical Records, If Such Information and/or Records Exist:

	Please send the entire Medical Record (all information) to the above named recipient.				
☐	Office Notes and Reports	☐	Most recent one year history	☐	Most recent three-year history
☐	Rx History	☐	Transcribed hospital reports	☐	Laboratory reports
☐	Billing Statements	☐	Diagnostic Reports	☐	Diagnostic Films
☐	Others Listed Here:				
For dates: From:			To:		

The Following Items Must Be Initialed to Be Included in the Use And/or Disclosure:

_____ I understand that a complete copy of my medical records may include confidential information such as mental health, alcohol and/or drug abuse, HIV and other STD results. I also understand that if I want this information excluded from the copies, I must indicate this in writing.

☐ Drug/Alcohol diagnosis, treatment or referral information (Federal regulations require a description of how much and what kind of information is to be disclosed.) Describe:

_____

I understand that, if the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by HIPAA and other federal and state regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

I also understand that the person I am authorizing to use and/or disclose the information may not receive compensation for doing so.

I further understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment of my eligibility for benefits. I may inspect or copy any information to be used and/or disclosed under this authorization.

Finally, I understand that **I may revoke this authorization**, in writing, at any time, provided that I do so in writing, except to the extent that action has been taken in reliance upon this authorization. Unless Revoked Earlier, this Authorization Will Expire in Six (6) Months from the Date of Signing or until (Insert Date)_____.

Patient Name (Print):	
Patient Signature:	Date:
Legal Guardian Name:	Legal Rep. Signature:

1405 SW 6th St., Ocala, Fl 34471 P: 352-421-5858

HIPAA NOTICE OF PRIVACY PRACTICES

Effective Date: March 26, 2013

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 is provided to you pursuant to the Health Insurance Portability and Accessibility Act of 1996 and its implementation regulations ("HIPAA"). It is designed to tell you how we may, under federal law, use or disclose your Health Information. It has been updated to the HITECH Omnibus Rule requirements.

I. Your Rights.

You have the right to request restrictions on the uses and disclosures of your Health Information. However, we are not required to comply with all requests. You are allowed to restrict transmittal of health care charges to your insurance carrier if you pay for those services, in full, by other means.

You have the right to receive your Health Information through confidential means and in a manner that is reasonably convenient for you and us.

You have the right to inspect and copy your Health Information. You may request your records in digital format and have your records sent digitally to another provider with written authorization.

You have a right to request that we amend your Health Information that is incorrect or incomplete. We are not required to change your Health Information and will provide you with information about our denial and how you can disagree with the denial.

You have a right to receive an accounting of disclosures of your Health Information made by us, except that we do not have to account for disclosures: authorized by you; made for treatment, payment, health care operations; provided to you; provided in response to an Authorization; made in order to notify and communicate with approved family members; and/or for certain government functions, to name a few.

You have been provided with a paper copy of this Notice of Privacy Practices. If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, please contact our HIPAA Compliance Officer at Essential Woman, LLC.

II. We May Use or Disclose Your Health Information for Purposes of Treatment, Payment or Healthcare Operations without Obtaining Your Prior Authorization and Here is One Example of Each:

We may provide your Health Information to other health care professionals — including doctors, nurses and technicians — for purposes of providing you with care.

Our billing department may access your information — and send relevant parts to insurance companies to allow us to be paid for the services we render to you.

We may access or send your information to our attorneys or accountants in the event we need the information in order to address one of our own business functions. Our attorneys and accountants are required to maintain confidentiality when they receive patient information.

III. We May Also Use or Disclose Your Health Information Under Certain Circumstances without Obtaining Your Prior Authorization.

However, in general, we will attempt to ensure that you have been made aware of the use or disclosure of your Health Information prior to providing it to another person. Some instances where we may need to disclose information include but are not limited to:

To Notify and/or Communicate with Your Family. We will only communicate with family members that we are authorized to communicate with based on your completion of the Authorization to Disclose Health Information to Family and Friends form.

As Required By Law. For Health Oversight Activities. We may use or disclose your Health Information to health oversight agencies during the course of audits, investigations, certification and other proceedings.

In Response to Civil Subpoenas or for Judicial Administrative Proceedings. We may use or disclose your Health Information, as directed, in the course of any civil administrative or judicial proceeding.

To Law Enforcement Personnel. We may use or disclose your Health Information to a law enforcement official to comply with a court order or grand jury subpoena and other law enforcement purposes.
For Purposes of Organ Donation. We may use or disclose your Health Information for purposes of communicating to organizations involved in procuring, banking or transplanting organs and tissues. For Worker's Compensation. We may use or disclose your Health Information as necessary to comply with worker's compensation laws.

IV. For All Other Circumstances, We May Only Use or Disclose Your Health Information After You Have Signed an Authorization. If you authorize us to use or disclose your Health Information for another purpose, you may revoke your authorization in writing at anytime. Fundraising. Should our practice use patient information for fund raising we will inform individuals that they have the right to opt out of fundraising solicitations and explain that process. You do have the capability to opt back in should with written notice.
• Marketing. Should our practice use patient information for marketing purposes we will first obtain your written authorization and fully explain the uses and disclosures of PHI for marketing purposes, and disclosures that constitute a sale of PHI require will require a separate written authorization.
• Use or Disclosure of Psychotherapy Notes. *Written a*uthorization is required if our practice intends to use or disclose psychotherapy notes.
• Breach Notice. All patients will be informed if there is a breach, as defined by federal rules, of their unsecured protected health information as required by the HIPAA regulations. Right to Request Restrictions for Disclosures Related to Self-Payment. Our practice is required to comply with a request not to disclose health information to a health plan for treatment when the individual has paid in full out-of-pocket for a health care item or service and signed our "Do Not File Insurance Form".

V. You Should Be Advised that We May Also Use or Disclose Your Health Information for the Following Purposes:
Appointment Reminders. We may use your Health Information in order to contact you to provide appointment reminders or to give information about other treatments or health-related benefits and services that may be of interest to you.
Change of Ownership. In the event that our Business is sold or merged with another organization, your Health Information/record will become the property of the new owner.

VI. Our Duties.
We are required by law to maintain the privacy of your Health Information and to provide you with a copy of this Notice.
We are also required to abide by the terms of this Notice.
We reserve the right to amend this Notice at any time in the future and to make the new Notice provisions applicable to all your Health Information — even if it was created prior to the change in the Notice. If any such amendment is made that materially changes this Notice, we will send you another copy.

VII. Complaints to our Practice and the Government.
You may make complaints to our HIPAA Privacy Officer or the Security of the Department of Health and Human Services ("DHHS") if you believe your rights have been violated.
We will review all complaints in a professional manner and keep you informed of your rights as our patient.
We promise not to retaliate against you for any complaint you make about our privacy practices.

VIII. Contact Information.
You may contact us about our privacy practices or file a complaint by calling our Privacy Officer at 352-421-5858.

You may contact the DHHS at: The U.S. Department of Health and Human Services, 200 Independence Avenue, S. W., Washington, D.C. 20201, Telephone: 202-619-0257, Toll Free: 1-877-696-6775

ACKNOWLEDGEMENT OF RECEIPT FOR NOTICE OF PRIVACY PRACTICES

You May Refuse To Sign This Acknowledgement

I, _____, have
(Print Patient Name)

☐ received a copy of this Company's Notice of Privacy Practices ,

☐ refused a copy of this Company's Notice of Privacy Practices because I already understand my rights.

_____
(Please Print Name)

_____
(Signature)

_____
(Date)

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communication barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (Please Specify):
_____

INSURANCE OPT OUT / CASH PAY ONLY

Patient Name (*print name*):

It is our goal to provide you the very best service possible. As a service to our patients we are participating in a number of health plans, thereby making our services accessible to as many patients as possible, we also want to make our services affordable to you for a Non-Insurance Based Program.

Please initial each line item reviewed and sign below to confirm your understanding of our **OPT OUT** policy.

_____ (Initials) This confirms and identifies your understanding that we will NOT BILL your healthcare insurance provider for the Essential Woman, LLC health care services and you **OPT OUT** of this method for payment to Essential Woman, LLC. In this case we are not permitted to bill your insurance for any of our health care services.
All payments made to Essential Woman, LLC for health care services will be directly billed to you (the patient) as per our Cash Pay Plan.

PLEASE REVIEW and INITIAL FOR "OPT IN CASH PAY ":

_____ (Initials) You are **OPTING FULL IN as a CASH PAY** customer only. This includes the Provider Visit(s) and Essential Woman, LLC health care service or procedures, whereas you understand our cash pay fee schedule is based upon allowable rates and is provided to you at the time or before your visit, CASH PAYMENT IS DUE AT THAT TIME OF SERVICE or through our Recurring Payment Option(s). **We will not bill your insurance** for the Provider Visit. You will be responsible for payment for the Provider Visit(s) and services as provided.

_____ (Initials) You have reviewed our below **NO SHOW /CANCELLATION Policy** outline for your understanding:

1.) We request out of respect for other patients waiting for appointment(s), **please notify our office at least 24 Hours prior to your appointment date if you must CANCEL OR RESCHEDULE**. We are available to assist with rescheduling.
2.) If you do not contact our office, and are a **NO SHOW** at your scheduled procedure date/time you **MAY BE BILLED A $25.00 cancellation/no show fee** due to the cost involved for preparations of your scheduled appointment.

We sincerely hope these policies promote our overall goal of transparency and team-oriented health care. Please feel free to let us know if there are any items we can improve to make the administrative side of our practice as painless and easy for you as possible.

PATIENT ACKNOWLEDGEMENT

By my signature below, I acknowledge to have read the above polices and agree to the outlined terms. I understand my responsibilities and the consequences for violation of the financial or cancellation responsibilities. I was given opportunity to ask questions regarding the financial and cancellation policies and understand their impact on my relationship to the practice.

Patient Signature (*or legal guardian, please identify below*):	Date:
If signed by a legal guardian above, please print name and relationship to patient:	Relation: