GREATER CAROLINAS WOMEN'S CENTER

PATIENT – PHYSICIAN AGREEMENT

PATIENT NAME:_____

DATE:_____ DATE OF BIRTH:_____

It is the policy of Greater Carolinas Women' Center to provide excellent medical care to all our patients. Therefore, we reserve the right to discharge a patient that we feel does not adhere to the policies of the practice.

For any New Patient the policy is as follows:

New OB and/or suppressed menses patient with a No Show appointment – will not be rescheduled

Established OB patient – 2 No Show appointments – will not be rescheduled

Any OB patient will be rescheduled only once.

Any New and/or established GYN patient with 2 No Show appointments will not be rescheduled.

Any OB and/or GYN patient may be discharged from the practice at the physician's discretion due to non-compliance of treatment and/or excessive No Show record.

Please call 24 hours in advance to cancel appointments.

Patient Signature:_____ Date:_____

My signature on this document is an acknowledgement that I understand this agreement and I will abide by Greater Carolinas Women's Center contract. Failure to do so will determine whether I am to be terminated as a patient or remain a patient with the practice.

10.26.2015

Updated 11/20/2015

Greater Carolinas Women's Center

BLOOD AND/OR BLOOD PRODUCT WAIVER

Our top priority at Greater Carolinas Women's Center is your health and safety. We also find it important to recognize and respect your personal preference when it comes to medical treatment, specifically your right to accept or refuse blood and/or blood products.

This medical directive form is for you to let us know what you would want done for you in an unforeseen emergency/life-threatening situation, if you were not capable of telling us at that time.

_____ I will accept ANY blood product that my healthcare provider deems necessary in an emergency/life threatening situation.

_____ **I **REFUSE** all blood/blood products except those specifically initialed on the separate Carolinas Medical Centers-Charlotte Blood Management List of Treatments (see and sign separate form). *__**These may or may not be available at the time of service__*. **I WOULD RATHER DIE THAN BE GIVEN ANY BLOOD PRODUCTS UNAUTHORIZED BY ME PERSONALLY.**

I am signing this medical directive with the understanding that my decision to REFUSE recommended blood products may adversely affect my health and put my life at serious risk, __including death__. I release the physicians, his/her assistants, the office, the hospital, and its personnel from any responsibility whatsoever for any unfavorable results due to my refusal of blood products. I understand that this document will be held true and honored as above unless I __personally__ make the decision to change it. My next of kin or power of attorney will NOT be able to override the above stated medical directive; therefore, I understand the importance of sharing these wishes with them.

Patient Name:_____ Time:_____ Date:_____

Patient Signature:_____ Time:_____ Date:_____

Witness Signature:_____ Time:_____ Date:_____

Carolinas HealthCare System

GREATER CAROLINAS WOMEN'S CENTER

Thank you for coming in to see us today. We appreciate the opportunity to serve you and participate in your care.

We have recently had a difficult time contacting our patients either with results or answers to questions asked, because the contact numbers we have are old, outdated or incorrect. We realize this may be due to all the changes in cell phone systems and now Internet telephone services.

Please write down your current contact numbers. List all that you recommend we try.

Name:_____

Home:_____

Work:_____

Cell:_____

PLEASE CIRCLE THE NUMBER YOU MOST PREFER US TO USE WHEN CONTACTING YOU.

Please remember to call our office and update your contact information if this information changes while you are under our care!

Thank you for your cooperation.

Annual Physical Review

Name: _____ Reason for Visit: _____

Address: _____ Phone: _____

Date of Visit:_____ DOB : _____ Age: _____ Occupation:_____

Primary Care Physician Name & Phone #: _____

***ALLERGIES: _____

List of Current Medicines: _____

Single_____ Married_____ Divorced _____ Separated _____ Widowed_____ Domestic Partner_____

Do you use hormone replacement? Yes _____ No _____ Prescription Name: _____

Menstrual History: First Period (Age) _____ Last Menstrual Period: _____

Days of Flow _____ Amount: (heavy, normal, light) _____ Length between Periods: _____

Pregnancy:

Have you ever been pregnant? Yes _____ No _____ How many times: _____

Baby #1 Baby's Weight _____ DOB_____ Full Term ____ Pre Term____ Miscarriage ____ Vaginal or C-Section delivery _____

Baby #2 Baby's Weight _____ DOB_____ Full Term ____ Pre Term____ Miscarriage ____ Vaginal or C-Section delivery _____

Baby #3 Baby's Weight _____ DOB_____ Full Term ____ Pre Term____ Miscarriage ____ Vaginal or C-Section delivery _____

Baby #4 Baby's Weight _____ DOB_____ Full Term ____ Pre Term____ Miscarriage ____ Vaginal or C-Section delivery _____

Baby #5 Baby's Weight _____ DOB_____ Full Term ____ Pre Term____ Miscarriage ____ Vaginal or C-Section delivery _____

Any pregnancy complications: _____

Abortion _____ # of Living Children _____

Birth Control:

Do you use birth control?

Pills _____ Diaphragm _____ Depo Provera _____ Implanon/Norplant _____ Abstinence _____ None Needed ____

IUD _____ Vasectomy _____ Tubal Ligation _____ Condoms _____ Rhythm Method _____

Medical History: Check if you have had any of the following:

Yes___ No___ Cancer

Yes ___ No___ High Blood Pressure

Yes___ No ___ Anemia

Yes___ No ___ Depression

Yes___ No___ Abnormal Pap Smear

Yes ___ No___ Heart Disease

Yes___ No___ Thyroid Problems

Yes___ No___ Alcoholism

Yes___ No___ Pelvic Infection

Yes___ No ___ Mitral Valve Prolapse Yes___ No___ Diabetes Yes___ No___ Digestive Problems

Yes___ No ___ Sexually Transmitted Disease Yes ___ No ___ High Cholesterol Yes___ No ___ Tuberculosis

Yes___ No ___ Drug Addiction Yes___ No ___ Phlebitis/Blood Clots in legs Yes ___No ___Migraine Headaches

Yes__ No ___ Hepatitis Yes___ No ___ Infertility

Date of Last: Colonoscopy _____ Bone Density _____ HPV vaccine _____ Gardasil _____

Do you perform breast exams on yourself? Yes___ No___ How often? _____

Have you had a mammogram of your breasts? Yes___ No___ If so, date? _____

Have you ever had an abnormal mammogram? Yes___ No___ If so, date? _____

Have you ever had an abnormal pap smear? Yes___ No___ If yes, what kind of treatment? _____

Do you have a pap smear yearly? Yes___ No___ If so, when was the last one performed? _____

Surgical History:

Have you had any female surgery?

If so, indicate what type and indicate below the year surgery was performed?

Breast _____ Hysterectomy_____ D&C_____ Ectopic Pregnancy_____ Fibroid Tumors_____

Ovary_____ Laparoscopy_____ C-section_____ Laser/LEEP/Cryo of Cervix_____ Other_____

Reason for Surgery / Findings: _____

Please list any other surgery: (i.e. appendectomy, heart surgery) **Be sure to enter the date of surgery:**

_____

_____

_____

_____

Sexual Health:

Are you sexually active? Yes____ No____ Do you have sex with men, women or both? Men____Women____ Both ____

How many lifetime sexual partners? _____ New partner(s) in past year? _____

Do you use condoms? _____ Would you like STD screening? Yes____ No____

Social History / Habits:

Have you ever smoked? Yes___ No___ How much? _____ Quit?_____ Years?_____

Do you drink alcohol? Yes___ No___ How much? _____ How often? _____

Do you use street drugs? Yes___ No___ What kind? _____ How often? _____

Are you at risk for HIV infection? Yes___ No___

Are you or have you ever been threatened or physically, sexually or mentally abused? Yes___ No___

Do you exercise? Yes___ No___ How often? _____

Family History: (Siblings, Parents, Grandparents)
Please mark appropriate box if a family member currently has or previously had one of these illnesses. If yes, please list whether mother, father, grandmother, grandfather, sister, brother, etc.

Yes___ No___ Breast Cancer _____ Yes___ No___ Tuberculosis _____

Yes___ No___ Ovarian Cancer _____ Yes___ No ___ Diabetes _____

Yes___ No___ Other Cancer _____ Yes___ No___ Bleeding Disorder _____

Yes___ No___ Birth Defects _____ Yes ___ No___ Alcoholism _____

Yes___ No___ High Blood Pressure _____ Yes___ No___ Mental Retardation _____

Yes___ No___ Heart Attack _____ Yes___ No___ Osteoporosis/Osteopenia _____

Yes___ No___ High Cholesterol _____ Yes___ No___ Other _____

REVIEW OF SYSTEMS – Please check if you are having problems with any of the following:

Genital / Urinary

Yes___ No___ Vaginal Warts Yes___ No___ Heavy Vaginal Bleeding Yes___ No___ Painful Intercourse

Yes___ No___ Vaginal Dryness Yes___ No___ Irregular Vaginal Bleeding Yes___ No___ Urinary Urgency

Yes___ No___ Painful Menstrual Periods Yes___ No___ Pain / Burning with Urination

Yes___ No___ Urination at night Yes___ No___ Bladder Control / Leakage Yes___ No___ Urinary Tract Infections

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Endocrine

Yes___ No___ Fatigue Yes___ No___ Hair Loss Yes___ No___ Absence of Menstrual Periods Yes___ No___ Hot Flashes

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Skin / Breast

Yes___ No___ Nipple Discharge Yes___ No___ Sore that Does Not Heal Yes___ No___ Changes in Mole

Yes___ No___ Breast Lumps Yes___ No___ Breast Tenderness Yes___ No___ Rashes / Persistent Itching

---

Neurological

Yes___ No___ Frequent Headaches Yes___ No___ Poor Coordination

Yes___ No___ Muscle Weakness Yes___ No___ Trouble Sleeping

Psychiatric

Yes___ No___ Depression Yes___ No___ Anxiety Yes___ No___ Memory Changes

Yes___ No___ Mood Swings Yes___ No___ Counseling Treatment

Ear, Nose & Throat

Yes___ No___ Visual Problems Yes___ No___ Allergies / Hayfever Yes___ No___ Frequent Sore Throats

Yes___ No___ Mouth Ulcers Yes___ No___ Hearing Loss Yes___ No___ Hoarseness

Yes___ No___ Sinus Problems

Digestive

Yes___ No___ Heartburn Yes___ No___ Rectal Bleeding Yes___ No___ Diarrhea Yes___ No___ Yellow Jaundice

Yes___ No___ Vomiting Yes___ No___ Black Stools Yes___ No___ Significant Weight Change (i.e. < or > 10-15 lbs. / year)

Cardiac

Yes___ No___ Chest Pain Yes___ No___ Irregular Heart Beat Yes___ No___ Fainting / Dizziness

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Respiratory

Yes___ No___ Shortness of Breath Yes___ No___ Coughed Blood Yes___ No___ Wheezing

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GREATER CAROLINAS WOMEN'S CENTER
IMPORTANT INFORMATION REGARDING CHARGES

Greater Carolinas Women's Center practices comprehensive medical care focused on prevention as well as evaluation and management of your diseases, complaints and concerns. Insurance companies now dictate how physicians code and therefore, bill for these services.

A. Preventive Physical Exam (Annual Exam)
B. Office visits (Evaluation and Management Encounters, E&M Services)

A. **Preventive Physical Exams (Annual Exam)**
This is usually a visit/encounter to review preventive health issues such as:
Past medical history
Interim medical history since last physical exam
Immunizations
Health habits
Diet
Sleep pattern
Health maintenance issues such as last colonoscopy, last Mammography
Pertinent family history
Thorough physical exam including Pap Smear and necessary lab work

This visit is not designed to address specific complaints or to manage known medical problems. It is designed to educate you on changes you can make to live a healthier life and to identify potential health problems early.

B. **Office visits (Evaluation and Management Encounters, E&M Services)**
This encounter is designed for the evaluation and management of single or multiple complaints or disease processes such as:
Headaches
Gynecological problems
High blood pressure
Thyroid problems
Decreased libido
Depression
Menopausal therapy
Preconception counseling

If during your preventive physical exam your physician decides to include management of your existing and or any new medical problems; you are likely to be charged for both the preventive physical exam and office visit. The additional office visit may not be considered part of your preventive service benefit. Depending on your insurance benefit design, you may be required to pay the higher specialist co-pay and/or these charges may be applied to your out-of-pocket expense (i.e. deductibles or coinsurance).

Print Name_____ DOB_____

Patient Signature_____ Date_____

Patient Information: I give permission to release the health information of: **(One Patient Per Form)**

Patient Name: _____ Date of Birth: _____

Street Address: _____ Last 4 numbers of SSN: _____

City, State, Zip: _____ Telephone: ( ) _____

Email address: _____

Release Information From:	**Release Information To:**
_____ (List applicable Facility(s) and/or Practice(s))	_____ (Name of facility, person, company) (Relationship)
_____	_____ (Street Address or PO Box, City, State, Zip Code)
_____ (Phone number) (Fax number)	_____ (Phone number) (Fax number)

PURPOSE OF RELEASE (check reason): ☐ Request of individual/personal ☐ Continued patient care ☐ Insurance
☐ Legal purpose including discussions & proceedings ☐ Other _____

Fill in dates of treatment for records to be released:

Treatment dates: From _____ **To** _____

Hospital Summary: May include history & physical, discharge summary, operative notes, consults, diagnostic test results, medication list, allergies.
Office/Clinic Summary: May include most recent office visits, physical exam, consults, diagnostic test results.

Hospital (check all that may apply):	**Office/Clinic (check all that may apply):**	**Behavioral Health/Sub. Abuse (check all that may apply):**
☐ Hospital Summary	☐ Office/Clinic Summary	☐ Hospital Summary
☐ Discharge Summary ☐ Emergency Record	☐ Office Visits	☐ Assessments
☐ History and Physical ☐ Cardiac Reports/EKG	☐ Physical Exam	☐ Discharge Summary
☐ Consultation reports ☐ Other _____	☐ Laboratory Reports	☐ Physician Orders
☐ Operative Reports _____	☐ Radiology Reports	☐ Progress notes
☐ Laboratory reports _____	☐ Other _____	☐ Medications
☐ Radiology/X-Ray Reports _____	_____	☐ Lab reports
☐ Pathology reports _____	☐ Entire Record (Not including psychotherapy notes)	☐ Other _____
☐ Entire record (Not including psychotherapy notes)		☐ Entire Record (Not including psychotherapy notes)

FORMAT:	**DELIVERY METHOD:**
☐ CD (charges may apply)	☐ Reg.US Mail ☐ Pick-up ☐ Fax, where permitted
☐ Email Address noted above, where permitted	☐ Overnight/Express Mail Service, where permitted
☐ Paper copy (charges may apply)	☐ Secure email
☐ Other _____	☐ Other: _____

PATIENT'S RIGHTS – I understand that:

- **I can cancel this permission at any time. I must cancel in writing and send or deliver cancellation to releasing facility or practice named above. Any cancellation will apply only to information not yet released by facility or practice.**
- **This is a full release including information related to behavioral/mental health, drug and alcohol abuse treatment (in compliance with 42 CFR Part 2), genetic information, HIV/AIDS, and other sexually transmitted diseases.**
- **Once my health information is released, the recipient may disclose or share my information with others and my information may no longer be protected by federal and state privacy protections.**
- **Refusing to sign this form will not prevent my ability to get treatment, payment, enrollment in health plan, or eligibility for benefits.**
- **CHS will not share or use my health information without my permission other than by ways listed in CHS's Notice of Privacy Practices or as required by law. The Notice of Privacy Practices is available at carolinashealthcare.org.**
- **A fee may be charged for providing the protected health information.**
- **I have a right to receive a copy of this form upon request.**

This permission expires one year after the date of my signature unless another date or event is written here: _____

Signature: _____ **Print Name:** _____ **Date:** _____

Note: If the patient lacks legal capacity or is unable to sign, an authorized personal representative may sign this form.
Note the relationship/authority if signature is not that of the patient (Written Proof May be Requested):
☐ **Healthcare Agent/POA** ☐ **Guardian** ☐ **Executor/Administrator/Attorney in Fact** ☐ **Spouse**
☐ **Parent** ☐ **Adult Child** ☐ **Affidavit Next of Kin** ☐ **Other:** _____

Note: If minor consented for their outpatient treatment for pregnancy, sexually transmitted disease or behavioral/mental health without parental consent, the minor must sign this authorization. When the patient is a minor being treated for substance abuse, the minor must sign this authorization, regardless of who consented for treatment.

Signature of Minor: _____ **Print Name:** _____ **Date:** _____

Authorization given to patient / Date of release: _____ via ☐Mail ☐Fax ☐Other _____ ☐ID Verified ☐DL/Other ID _____
CHS Employee Name & Title: _____ **CHS Employee Signature:** _____ **Date:** _____

Carolinas HealthCare System
AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Information or Sticker

Name:
DOB:
Medical Record #:
Account #:

Greater Carolinas Women's Center
Prescription Refill Policy

Requests for prescription refills should be called in to the patients' pharmacy by the patient. The pharmacy will notify Greater Carolinas Women's Center via fax that the patient has requested the refill and request approval from the prescribing provider.

Patients should allow two business days for prescriptions to be either approved or denied by the prescribing provider.

Medication refills or changes to existing prescriptions will not be made after normal business hours, on weekends or holidays.

Refills on narcotics and controlled substances should be requested by calling the office and speaking to a member of our Live Answer Staff. When calling our office, patients will be advised by our telephone staff that they must allow two business days before the prescription will be available for pick up in our office (refills on narcotics and controlled substances only).

In the event that a patient presents at the front desk and requests a refill on a narcotic or controlled medication, a message will be taken and treated as a normal prescription refill request. Patients are informed that we will not be able to call a nurse to the Front Desk to assist them with their prescription request.

Patients are told to check with their pharmacy, if a patient has requested that we call in a prescription to a local pharmacy. A member of our nursing staff will notify patients via telephone when their written prescription (for narcotics and/or controlled substance prescriptions only) is ready to be picked up. In both instances, patients must allow two business days for their request to be either approved or denied.

Thank you for your cooperation in this matter.

The Physicians of Greater Carolinas Women's Center

Carolinas HealthCare System

Changes to Hydrocodone Prescriptions:

Effective Monday Oct. 6th, 2014

New rules have been mandated by the DEA for prescribing Hydrocodone. This includes the following products - Vicodin®, Lortab®, Norco®.

When a Hydrocodone-containing product(s) (HCP) are prescribed:

- Hydrocodone can no longer be ordered with refills.
- Hydrocodone can no longer be called in to your pharmacy.
- Patients will need to bring an original "paper" prescription to the pharmacy.
- Prescription requests for Hydrocodone, received by phone or secure message, will result in a paper prescription that must be picked up if authorized. These printed prescriptions will need to be picked up at the office during regular office hours.
- Patients will need to see their Provider at least every 3 months for additional prescriptions.

Prevention is the Best Medicine.

At Carolinas HealthCare System, our primary care doctors focus on preventive care that puts you in top form to fight off disease and illness so you can live the best life possible.

Preventive services covered by most health plans are listed below.

Coverage for Preventive Services

Adult Preventive

Exams:
Preventive office visits including well woman exams*

Screening Tests:
- Blood pressure screening for adults
- Cholesterol screening for adults of certain ages or at higher risk
- Colorectal cancer screening for adults over 50
- Diabetes (Type 2) screening for adults with high blood pressure
- Diet counseling for adults at higher risk for chronic disease

Immunizations:
Doses, recommended ages and populations vary
- Influenza (flu)
- Pneumonia
- Hepatitis A
- Hepatitis B
- Tetanus, Diphtheria, Pertussis (Td/Tdap)
- Varicella (chicken pox)
- Measles, Mumps, Rubella (MMR)
- Meningococcal
- Zoster (shingles)
- Human Papillomavirus (HPV)

Child Preventive

Exams:
Preventive office visits including well-child care*

Screening Tests:
- Hearing
- Vision
- Phenylketonuria (newborns)
- Sickle cell disease (newborns)

Immunizations:
Vaccines for children, birth to age 18 – doses, recommended ages and populations vary
- Influenza (flu)
- Pneumonia
- Hepatitis A
- Hepatitis B
- Tetanus, Diphtheria, Pertussis (Td/Tdap)
- Varicella (chicken pox)
- Measles, Mumps, Rubella (MMR)
- Polio
- Rotavirus
- Meningococcal
- Human Papillomavirus (HPV)
- Hib (Haemophilus influenza type b)

Newborn Preventive Treatment:
Ocular medication against gonorrhea for all newborns

* During an annual preventive exam, your physician may address new or pre-existing health conditions or concerns not considered part of your preventive service benefit. Should this occur, the additional services may not be considered part of your preventive services benefit, therefore, your insurance carrier may subject these additional services to your deductible and co-insurance provisions.

Certain history of symptoms or certain screenings, such as a colonoscopy, may identify health conditions that require further testing or treatment. If a condition is or has been identified through a preventive screening, any testing, diagnosis, analysis or treatment are not considered preventive services and are subject to any related copays and deductibles within your health plan.

The services listed are subject to change as federal guidelines are issued. A full list of covered preventive services can be found at www.healthcare.gov/what-are-my-preventive-care-benefits/

Carolinas HealthCare System

Carolinas HealthCare System

Thank you for choosing Carolinas HealthCare System for your healthcare needs. You are scheduled for an Annual Preventive Exam today and we want to provide you with some information regarding your visit.

What is part of preventive care?
Preventive care means that you and your doctor work together to lower your chance of getting certain health problems. During your visit, your doctor will choose what tests or health screenings are right for you. The tests chosen depend on your age, sex, past health record and your health now. As part of your visit you may have physical exams, immunizations, lab tests and other tests. Most health plans pay for these tests.

What is <u>not</u> part of preventive care?
New or current health problems are not part of preventive care. Your doctor can diagnose or treat any new or current health problem during your visit. Tell your doctor if you want that done. You may be charged for extra office or lab fees. This is a Carolinas HealthCare System policy. You will need to pay for some or all of the fees not covered by your health plan. Check your health plan to know what it will pay for.

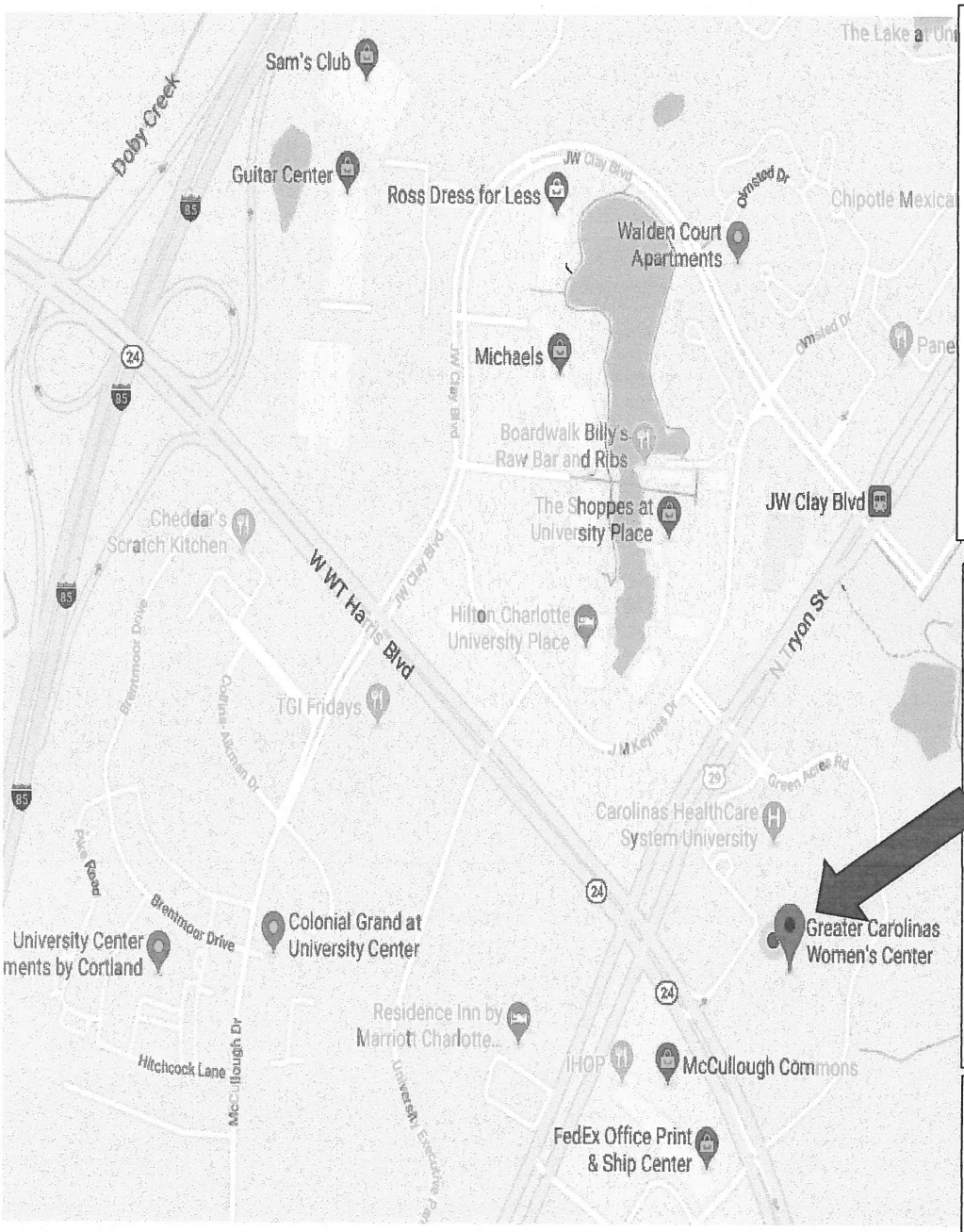
You may want to keep your annual preventive exam apart from new or current health problems. We can set up a separate visit for you. You will still be charged for care and tests that are not covered by your health plan.

Thank you for letting us help you stay healthy.

Greater Carolinas Women's Center

Directions to University Medical Park

101 East WT Harris Blvd
Ste 2320
Charlotte, NC 28262
704-547-0858



Driving Directions

From I-77 going South:

Take I-77 S, Use the right 2 lanes to take exit 19B-A toward I-85 N/Matthews. Keep left, follow signs for I-485 and merge onto I-485 N/I-485 Inner N. Take exit 45A for E/Harris Blvd. Pass under the light rail bridge and take the second left. The office is on the left inside the University Medical Park. (Building 2000 on the 3rd floor)

From I-77 going North (from downtown):

Take I-77 N, Use the right 2 lanes to take exit 13A to merge onto I-85 N toward Greensboro. Take exit 45A for E/Harris Blvd. Pass under the light rail bridge and take the second left. The office is on the left inside the University Medical Park. (Building 2000 on the 3rd floor)

From 1-85 going South or North

Take exit 45A for NC-24 E/Harris Blvd. Pass under the light rail bridge and take the second left. The office is on the left inside the University Medical Park. (Building 2000 on the 3rd floor)