Right to a Paper Copy of This Notice: You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our website, www.swch.net.

Changes to this Notice: We reserve the right to change this notice and make the revised notice effective for information we already have about you as well as any future information. We will post a copy of the current notice in the office. Each time you register at the office we will offer a copy of the current notice.

Complaints:
If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing.

You will not be penalized for filling a complaint.

To file a complaint with the office,

Contact Officer: Tracey Barb (Practice Manager) or email- tbarb@swhc.net

Telephone: (540) 438-1314 Toll Free: (877) 438-1314 Fax: (540) 438-0797

Address: 240 Lucy Drive, Harrisonburg, VA 22801

Other Uses of Medical Information:

Other uses and disclosures of information not covered by this notice will be made only with your written permission. You may revoke that permission in writing at any time. nderstand that we are unable to take back any permitted disclosures, and that we are required to retain records of your care.

HIPAA Notice of Privacy Practice

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.

Our Pledge Regarding Medical Information:

We understand that medical information about you and your health is personal. We are committed to protecting your medical information. We create a record of the care you receive at this office to provide you with quality care and to comply with legal requirements. This notice will tell you about the ways in which we use and disclose your medical information. We also describe your rights and the obligations we have regarding the use and disclosure of medical information. We are required by law to make sure that medical information that identifies you is kept private; give you this notice our privacy practices with respect to your medical information, and follow the terms of the current notice.

Who Will Follow This Notice:
This notice describes our office's practices. We may share information with each other for your care.

How We May Use and Disclose Medical Information About You:

For Treatment: We may use information about you to provide you with medical treatment. We may disclose medical information about you to office staff and others involved in you care.

For Payment: We may use and disclose information about you for insurance and payment services.

For Health Care Operations: We may use and disclose information about you for practice operations to make sure that you receive quality care and for learning purposes.

Appointment Reminders: We may use and disclose information to contact you about appointments.

Phone Messages. We may call and leave messages with whoever answers the phone at your house or on your answering machine unless directed otherwise.

Treatment Alternatives. We may use and disclose information to tell you about treatment options.

Health-Related Benefits and Services. We may tell you about health-related benefits or services.

Individuals Involved in Your Care or Payment for Your Care. We may release medical information about you to a friend or family member who is involved in or helps pay for your medical care. We may disclose medical information about you to assist in a disaster relief effort.

As Required By Law. We will disclose information about you when required to do so by law.

To Avert a Serious Threat to Health or Safety. We may use and disclose information about you to prevent a serious threat to your health and safety, the public or to another person.

Special Situations:

Organ and Tissue Donation. If you are an organ donor, we may release information to organ banks.

Military and Veterans. We may release information about military personnel as required.

Workers' Compensation. We may release information about you for workers' compensation.

Public Health Risks. We may disclose information about you for public health activities.

Health Oversight Activities. We may disclose information to a health oversight agency.

Lawsuits and Disputes. We may disclose information about you in response to a court or administrative order, a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request.

Law Enforcement. We may release information to a law enforcement official as required by law.

Coroners, Medical Examiners and Funeral Directors. We may release information to a coroner, medical examiner or funeral directors as necessary.

National Security and Intelligence Activities and Protective Services for the President. We may release information about you to authorized federal officials for national security activities.

Inmates. We may release information about inmates to a correctional institutions or law enforcement.

You have the following rights regarding medical information we maintain about you.

Right to Inspect and Copy. You have the right to inspect and copy your medical information. This includes medical and billing records, but does not include psychotherapy notes. You must submit your request in writing to Shenandoah Women's HealthCare. We may charge a fee for the costs of copying. We may deny your request to inspect and copy. You may request that the denial be reviewed. Another neutral health care professional, not the person who denied your request, will review your request and the denial. We will comply with the outcome of the review.

Right to Amend. If you feel that your information is incorrect or incomplete, you may ask us to amend the information. You may request an amendment as long as the office has this information. Your request must include the reason, be made in writing and submitted to Shenandoah Women's HealthCare. We may deny your request if you ask us to amend information not created by us, unless the person that created the information is no longer available; is not part of the information kept by the practice; is not information which you would be permitted to inspect and copy; or is accurate and complete.

Right to Accounting of Disclosures. You have the right to request a list of the accounting of disclosures we made of your medical information. You must submit your request in writing to Shenandoah Women's HealthCare. Your request must state a time period, not longer than six years, and indicate whether you want the list on paper or electronic. Your first requested list within a year is free.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Information we use or disclose about you for treatment, payment, and health care operations or to someone who is involved in your care or the payment for your care. **We are not required to agree with your request.** If we agree, we will comply with your request unless the information is needed in an emergency. You must make your request in writing to Shenandoah Women's HealthCare. You must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or location. You must make your request in writing to Shenandoah Women's HealthCare. We will not ask you the reason for your request, your request must specify how or where you wish to be contacted.
We have the right to deny your request.

Please note that there is a $26.00 No Show Fee that will be applied to your account if you

DO NOT cancel 24 hours prior to your appointment.

GET CONNECTED WITH OUR PATIENT PORTAL!

1. **View test and lab results**
2. **Request RX refills**
3. **Request appointments**
4. **Send and receive secure online messages**

Get registered by giving our front office staff your email address upon check-in.

Office Use Only:
Patient Number _______________

Shenandoah Women's HealthCare
&
The Spa at Shenandoah

Name____ Birthdate: ____/____/____ Age: ______________
Marital Status: __________ Social Security Number: _____-_____-_____ Email: ____________________________
Address: ______________________________________ City: ________________ State: ______ Zip: __________
Phone Number: Home________________________ Cell____________________ Work______________________
Employer: _________________________________ Address: ____
Spouse Name: ____ Birthdate: ____________________________
Spouse Social Security Number: _____-_____-_____ Contact Number: __________________________________
Spouse Employer: _________________________________ Address: _____________________________________

Do you have insurance? ______ If not, how do you intend to pay? _____ Cash _____Check _____Credit Card

Primary Insurance Company :__________________________ Policy Holder's Name:_________________________
Identification Number:__________________________ Policy Holder's Birthdate: _________/_________/________
Policy Holder's Social Security:_________-_________-_________

Secondary Insurance Company :__________________________ Policy Holder's Name:________________________
Identification Number:__________________________ Policy Holder's Birthdate: _________/_________/________
Policy Holder's Social Security:_________-_________-_________

Nearest relative not living with you:_____________________________ Phone Number:______________________
Address:____Relationship:________________________

Financial Information

Assignment of Benefits

I herby authorize direct payment of medical benefits to this office for services rendered. I understand that I am financially responsible for a charges incurred by me regardless of insurance coverage.

Release of Information

I authorize the release of any information necessary for medical care or for processing insurance claims.

Financial Policy

Office visit copays are due at the time of service. Arrangements may be made for balances left unpaid by insurance companies. In the event my account is turned over for outside collections I agree to pay all cost related to collections, to include court costs, reasonable attorney fees, a 25% collection fee and 18% interest.

Signed____ **Date**___________________________

____Date____________________________
(Parent of Legal Guardian if patient is under 18 years of age)

Authorization for Release of Information

Name of Patient ____ Date of Birth ______________

Shenandoah Women's HealthCare is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Entity to Receive Information. Check each person/entity that you approve to receive information.	**Description of information to be released.** Check each that can be given to person/entity on the left in the same section.
❑ Voice Mail	❑ Results of lab tests/x-rays Other_______________________________
❑ Spouse (provide name & phone number) ______________________________________	❑ Financial ❑ Medical as follows:____________________ ____________________________________
❑ Parent (provide name & phone number) ______________________________________	❑ Financial ❑ Medical as follows:____________________ ____________________________________
❑ Other (provide name & phone number ______________________________________	❑ Financial ❑ Medical as follows ____________________ ____________________________________

Patient Information
I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

____Date ____________________
Signature of Patient or Personal Representative
Description of Personal Representative's Authority (attach necessary documentation)

____

Revised January 2010

Shenandoah Women's HealthCare
The Spa at Shenandoah

Acknowledgement of Receipt Of Notice of Privacy Practices

Patient Name & Address: ____

____

____

I have received a copy of the Notice of Privacy Practices for the above named practice.

___________________________________ ________________________
Signature Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ❑ An emergency existed & a signature was not possible at the time.
- ❑ The individual refused to sign.
- ❑ A copy was mailed with a request for a signature by return mail.
- ❑ Unable to communicate with the patient for the following reason: ____
- ❑ Other:____
____

Prepared By ____

Signature ____

Date ____

Shenandoah WOMEN'S HEALTHCARE
PROFESSIONAL CARE WITH A PERSONAL TOUCH

The Spa at Shenandoah

Patient Intake Form

Patient Name	**Birth Date:**	**Age:**	**Date:**
Name you would like us to use:			
Work Telephone: ( )	Emergency Contact:		
Home Telephone: ( )	Relationship:		
Mobile Telephone: ( )	Telephone(s):		
Referred by:			
Why have you come to the office today?			
Please describe your problem, including where it is, how severe it is, and how long it has lasted?			
Office use only:			
Weight:	**Height:**	**BP:**	**Pharmacy:**

Gynecologic History

	Provider's Notes
Age periods started:	
Date last period began:	
How far apart are your periods?	
How long do they last?	
What do you use to prevent pregnancy?	
When was your last pap smear? Result:	
Have you ever had an abnormal pap smear?	
What was done?	
Last Mammogram: Date: Result:	
Bone Density Test: Date: Result:	
Colonoscopy: Date: Result:	
Would you like to be tested for STD's? ☐ Yes ☐ No	

If you are uncomfortable answering any questions, leave them blank; you can discuss them with your provider or nurse.

Acct. #:

Obstetric History

	Birth Date	Weight At Birth	Baby's Sex	Weeks Pregnant	Type Of Delivery: Vaginal, C-section, Miscarriage, or Elective Abortion	Complications?
1						
2						
3						
4						
5						
6						
Provider's Notes:						

Personal Past History of Illnesses

Major Illness	Yes (Date)	No	Provider's Notes
Asthma			
Kidney Infections/Stones			
Sexually Transmitted Disease			
Diabetes			
High Blood Pressure			
Stroke			
Blood Clots In Lungs/Legs			
Cancer			
Reflux			
Hiatal Hernia			
Ulcers			
Depression			
Anxiety			
Blood Transfusions			
High Cholesterol			
PCOS			
Thyroid Disease			
Injuries			
Other:			

If you are uncomfortable answering any questions, leave them blank; you can discuss them with your provider or nurse.

Social History

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Engaged	**Provider's Notes**
Sexual History: ☐ Never Sexually Active ☐ Not Currently Sexually Active ☐ Currently Sexually Active ☐ Men ☐ Women ☐ Both	
Level of School Completed:	
Occupation:	
Language Spoken:	
How often do you exercise? ☐ Minimal ☐ Regular ☐ Daily	
Diet: ☐ Regular ☐ Type:	
Tobacco: ☐ Never ☐ Past use, quit________ ☐ Current	
Caffeine: ☐ Never ☐ Rare ☐ Minimal ☐ Moderate	
Alcohol: ☐ Never ☐ Rare ☐ Minimal ☐ Moderate	
Recreational Drugs: ☐ Never ☐ Past ☐ Current, type____________	

Current Medications (Including hormones, vitamins, herbs, nonprescription medications

Name	Dose	How many times/day	Taken for what condition?	Who prescribed?

GYN Surgeries/Operations/Hospitalizations (ex: C-section, tubal ligation, ovarian cysts, LEEP, hysterectomy, etc.)

Date	Surgery	Reason	Provider's Notes

Allergies

Medication	Reaction

If you are uncomfortable answering any questions, leave them blank; you can discuss them with your provider or nurse.

Immunizations/Tests

	Yes	Not Sure	No	Date		Yes	Not Sure	No	Date
Tetanus-Diphtheria Booster					**Influenza Vaccine (Flu-Shot)**				
Hepatitis A Vaccine					**Hepatitis B Vaccine**				
Varicella Vaccine					**Pneumococcal Vaccine**				
Chicken Pox Disease					**Measles-Mumps-Rubella (MMR) Vaccine**				
Gardasil Vaccine					**Tuberculosis(TB) Skin Test**				
Result:									

Family History

(Please specify if Maternal (Mother's side) or Paternal (Father's side))

Mother: ☐ **Living** ☐ **Deceased-Cause: Age:**	**Father:** ☐ **Living** ☐ **Deceased-Cause: Age:**	
Siblings: Number Living: Number-Deceased: Cause(s)/Age(s):		
Children: Number Living: Number Deceased: Cause(s)/Age(s):		
Illness	**Which relative(s) and age of onset**	**Provider's Notes**
Cancer-Breast		
Cancer-Colon		
Cancer-Ovary		
Cancer-Uterus		
Stroke (CVA)		
Blood Clots		
Depression		
Diabetes		
Heart Disease		
High Cholesterol		
Hypertension		
Thyroid Disease		
Heart Attack (MI)		
Osteoporosis		

If you are uncomfortable answering any questions, leave them blank; you can discuss them with your provider or nurse.

	Now	Past	
1. General			
Fatigue			
Weight change			
2. Eyes			
Glasses/Contacts			
3. Ears/Nose/Throat			
Hearing problems			
4. Cardiac			
Chest pain			
Shortness of breath			
Shortness of breath w/ exercise			
5. Respiratory			
Cough			
Shortness of breath			
6. Gastrointestinal			
Constipation			
Diarrhea			
Blood in stool			
7. Genitourinary			
Pain w/ urination			
Leaking urine			
Vaginal bleeding			
8. Musculoskeletal			
Muscle/Joint pain			
9. Skin			
Rash			
Moles			
10. Breasts			
Masses			
11. Neurologic			
Headache			
12. Psychiatric			
Depression/Anxiety			
13. Endocrine			
Heat/Cold intolerance			
14. Hematologic			
Frequent bruises			
15. Allergies			
Seasonal			
16. Rheumatologic Disease			
Arthritis			
Other			
17. Urologic Problems			
Urinary Incontinence			
Recent UTI			
Other			
18. Other medical problems			
Forms completed by: ☐Patient ☐Nurse ☐Physician ☐Other:			
Patient Signature:		**Reviewed By:**	

If you are uncomfortable answering any questions, leave them blank; you can discuss them with your provider or nurse.