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.

Shenandoah WOMEN'S HEALTHCARE
PROFESSIONAL CARE WITH A PERSONAL TOUCH

HIPAA Notice of Privacy Practice

The Spa at Shenandoah

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

<u>DO NOT</u> 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 _____

Office use
Chart #

Shenandoah WOMEN'S HEALTHCARE
PROFESSIONAL CARE WITH A PERSONAL TOUCH

Intake Form

The Spa at Shenandoah

Your Name	Today's Date
Preferred Name	Preferred pronouns
Date of Birth	Age
Referred by	Primary Care Provider
What brings you to our office today?	
Office Use Only	
Weight:	Height:	BP:
Pharmacy	

General Health History

Age periods started:	Details
Date last period started:	
How far apart are your periods?	
How many days do you have your period?	
Do you want to get pregnant? Yes ☐ No ☐ If no, what are you using for contraception?	
Do you want STD testing today? Yes ☐ No ☐	
Have you ever had a pap smear? Yes ☐ No ☐ Date: Results:	
Any history of abnormal pap smears? Yes ☐ No ☐ Any treatment?	
Have you had a mammogram? Yes ☐ No ☐ Date: Results:	
Have you had a colonoscopy? Yes ☐ No ☐ Date: Results:	
Have you had a bone density test? Yes ☐ No ☐ Date: Results:	
Have you ever had a blood transfusion? Yes ☐ No ☐ Are you willing to accept blood products if necessary? Yes ☐ No ☐	

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

Office use
Chart #

Current Symptoms

Are you currently having …		Details
Fatigue	Yes ☐ No ☐	
Weight gain or loss	Yes ☐ No ☐	
Changes in Wart/Mole	Yes ☐ No ☐	
Rash	Yes ☐ No ☐	
Glasses/contact lenses	Yes ☐ No ☐	
Hearing loss	Yes ☐ No ☐	
Season allergies	Yes ☐ No ☐	
Cough	Yes ☐ No ☐	
Difficulty breathing	Yes ☐ No ☐	
Breast mass or pain	Yes ☐ No ☐	
Chest pain	Yes ☐ No ☐	
Shortness of breath w/ exercise	Yes ☐ No ☐	
Irregular Heart Beat	Yes ☐ No ☐	
Bloody stool	Yes ☐ No ☐	
Constipation	Yes ☐ No ☐	
Diarrhea	Yes ☐ No ☐	
Painful urination	Yes ☐ No ☐	
Leaking urine	Yes ☐ No ☐	
Postmenopausal vaginal bleeding	Yes ☐ No ☐	
Vaginal odor/itching	Yes ☐ No ☐	
Vaginal dryness	Yes ☐ No ☐	
Vaginal / Vulvar pain	Yes ☐ No ☐	
Abnormal vaginal discharge	Yes ☐ No ☐	
Pain with intercourse	Yes ☐ No ☐	
Painful periods	Yes ☐ No ☐	
Heavy periods	Yes ☐ No ☐	
Joint pain/swelling	Yes ☐ No ☐	
Muscle pain	Yes ☐ No ☐	
Headaches	Yes ☐ No ☐	
PMS symptoms	Yes ☐ No ☐	
Mood changes (anxiety, depression)	Yes ☐ No ☐	
Heat/Cold intolerance	Yes ☐ No ☐	
Easy Bruising	Yes ☐ No ☐	

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

Office use
Chart #

Past Health History

Any history or current:		Details
Abuse (sexual, physical, emotional)	Yes ☐ No ☐	
Asthma	Yes ☐ No ☐	
Blood Clots	Yes ☐ No ☐	
Cancer	Yes ☐ No ☐	
Chicken Pox	Yes ☐ No ☐	
Diabetes	Yes ☐ No ☐	
Uterine problems (fibroids, polyps, etc)	Yes ☐ No ☐	
High Blood Pressure	Yes ☐ No ☐	
High Cholesterol	Yes ☐ No ☐	
Kidney Disorder (stones, infections, etc)	Yes ☐ No ☐	
Injuries (broken bones, etc)	Yes ☐ No ☐	
Mood Disorders (depression, anxiety, bipolar, etc)	Yes ☐ No ☐	
Ovarian cysts	Yes ☐ No ☐	
PCOS	Yes ☐ No ☐	
Seizure disorder	Yes ☐ No ☐	
Sexually Transmitted Infections (chlamydia, HPV, Herpes, etc)	Yes ☐ No ☐	
Stroke	Yes ☐ No ☐	
Stomach issues (GERD, hernias, ulcers, IBS, etc)	Yes ☐ No ☐	
Thyroid disease	Yes ☐ No ☐	
Other medical issue not listed above		

Surgical History (include LEEP, cesareans, D&C, etc)

Surgery	Date	Why?	Details

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

Office use
Chart #

Allergies (list medications, foods, latex)

Allergen	Reaction

Your Current Medications (please include hormones, vitamins, supplements, non-prescription medications)

Name & Dose	How often?	For what reason?	Who prescribed it?

Pregnancy History (please include all pregnancies, including miscarriages and elective abortions)

	Date	Type of Birth (vaginal, cesarean, miscarriage, abortion)	Weeks pregnant	Baby's Sex	Baby's weight	Complications
1						
2						
3						
4						
5						
6						
7						
Current number of living children:						
Number of deceased children: Cause/Age:						

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

Office use
Chart #

Family History

I don't know my family history. ☐			
Mother: Living? ☐ If deceased, age?		Cause:	
Father: Living? ☐ If deceased, age?		Cause:	
Siblings: How many total? _____ How many living? _____ How many deceased? _____ If deceased, age (s)?		Cause(s):	
Illnesses		If yes, please detail which relative, age of onset, mother or father's side.	Details
Cancer – Breast	Yes ☐ No ☐		
Cancer – Colon	Yes ☐ No ☐		
Cancer – Ovary	Yes ☐ No ☐		
Cancer – Uterus	Yes ☐ No ☐		
Mood disorder (anxiety, depression, suicide)	Yes ☐ No ☐		
Diabetes	Yes ☐ No ☐		
Heart Disease (heart attack)	Yes ☐ No ☐		
High Cholesterol	Yes ☐ No ☐		
High Blood Pressure	Yes ☐ No ☐		
Stroke or Blood Clots	Yes ☐ No ☐		
Substance abuse (alcohol, drugs)	Yes ☐ No ☐		
Thyroid disease	Yes ☐ No ☐		
Osteoporosis	Yes ☐ No ☐		

Lifestyle History

Marital Status: Single ☐ Engaged ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐	Details
Sexual History: Never sexually active ☐ Not currently sexually active ☐ Currently sexually active with men ☐ women ☐ both ☐ Your sexual orientation	
Language(s) spoken:	
Highest level of schooling:	
Religious affiliation:	
Nutrition: Regular ☐ Other ☐ Describe:	
Exercise: Never/Rarely ☐ Every other day ☐ Daily ☐ Describe:	
Caffeine Use: Never/Rarely ☐ Minimal ☐ Moderate ☐	

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

Office use
Chart #

Lifestyle History (continued from previous page)

In the past month, have you drunk any alcohol or used other drugs? How many **days per month do you drink? _____** How many **drinks on any given day? _____** How often did you have **4 or more drinks per day in the last month? _____**	Yes ☐ No ☐
Have you smoked any cigarettes in the past 3 months? If yes, list cigarettes per day ____	Yes ☐ No ☐
Do your friends have a problem with alcohol or other drug use?	Yes ☐ No ☐
Does your partner have a problem with alcohol or other drug use?	Yes ☐ No ☐
Are you feeling at all unsafe in any way in your relationship with your current partner or at home?	Yes ☐ No ☐
Over the last few weeks, has worry, anxiety, depression or sadness made it difficult for you to do your work, get along with people, or take care of things at home?	Yes ☐ No ☐
In the past, have you had difficulties in your life due to alcohol or other drugs, including prescription medications?	Yes ☐ No ☐

Immunizations/Screenings

	Yes	Date	No	Not sure		Yes	Date	No	Not Sure
TDAP					Flu Shot				
Hepatitis A					Pneumococcal				
Hepatitis B					MMR				
Varicella					TB Test				
Gardasil					COVID vaccine				
Shingles					Type:				
Details:									

Any additional information that we need to know to better take care of you:

Forms completed by Patient ☐ Nurse ☐ Provider ☐ Other ☐	
Patient Signature:	Reviewed by:

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