

**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](http://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 filing a complaint.**

To file a complaint with the office,

Contact Officer: Tracey Barb (Practice Manager) or email- [tbarb@swchc.net](mailto:tbarb@swchc.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. Understand 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.**

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**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 your 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 \$50.00 No Show Fee that will  
be applied to your account if you**

**DO NOT cancel 24 hours prior to your appointment.**

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## **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 hereby 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.

<b>Entity to Receive Information.</b> Check each person/entity that you approve to receive information.	<b>Description of information to be released.</b> Check each that can be given to person/entity on the left in the same section.
<input type="checkbox"/> Voice Mail	<input type="checkbox"/> Results of lab tests/x-rays Other _____
<input type="checkbox"/> Spouse (provide name & phone number) _____	<input type="checkbox"/> Financial <input type="checkbox"/> Medical as follows: _____
<input type="checkbox"/> Parent (provide name & phone number) _____	<input type="checkbox"/> Financial <input type="checkbox"/> Medical as follows: _____
<input type="checkbox"/> Other (provide name & phone number) _____	<input type="checkbox"/> Financial <input type="checkbox"/> 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)

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**Shenandoah Women's HealthCare  
The Spa at Shenandoah**

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**Acknowledgement of Receipt  
Of Notice of Privacy Practices**

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Patient Name & Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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For Office Use Only

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**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 \_\_\_\_\_

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Office use  
Chart #

## Intake Form



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 <input type="checkbox"/> No <input type="checkbox"/> If no, what are you using for contraception?	
Do you want STD testing today? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Have you ever had a pap smear? Yes <input type="checkbox"/> No <input type="checkbox"/> Date:            Results:	
Any history of abnormal pap smears? Yes <input type="checkbox"/> No <input type="checkbox"/> Any treatment?	
Have you had a mammogram? Yes <input type="checkbox"/> No <input type="checkbox"/> Date:            Results:	
Have you had a colonoscopy? Yes <input type="checkbox"/> No <input type="checkbox"/> Date:            Results:	
Have you had a bone density test? Yes <input type="checkbox"/> No <input type="checkbox"/> Date:            Results:	
Have you ever had a blood transfusion? Yes <input type="checkbox"/> No <input type="checkbox"/> Are you willing to accept blood products if necessary? Yes <input type="checkbox"/> No <input type="checkbox"/>	

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

### Current Symptoms

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

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



### Past Health History

Any history or current:		Details
Abuse (sexual, physical, emotional)	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Asthma	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Blood Clots	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Cancer	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Chicken Pox	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Diabetes	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Uterine problems (fibroids, polyps, etc)	Yes <input type="checkbox"/> No <input type="checkbox"/>	
High Blood Pressure	Yes <input type="checkbox"/> No <input type="checkbox"/>	
High Cholesterol	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Kidney Disorder (stones, infections, etc)	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Injuries (broken bones, etc)	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Mood Disorders (depression, anxiety, bipolar, etc)	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Ovarian cysts	Yes <input type="checkbox"/> No <input type="checkbox"/>	
PCOS	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Seizure disorder	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Sexually Transmitted Infections (chlamydia, HPV, Herpes, etc)	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Stroke	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Stomach issues (GERD, hernias, ulcers, IBS, etc)	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Thyroid disease	Yes <input type="checkbox"/> No <input type="checkbox"/>	
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.*

**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.*

### Family History

I don't know my family history. <input type="checkbox"/>			
Mother: Living? <input type="checkbox"/> If deceased, age? _____		Cause: _____	
Father: Living? <input type="checkbox"/> 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 <input type="checkbox"/> No <input type="checkbox"/>		
Cancer – Colon	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Cancer – Ovary	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Cancer – Uterus	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Mood disorder (anxiety, depression, suicide)	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Diabetes	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Heart Disease (heart attack)	Yes <input type="checkbox"/> No <input type="checkbox"/>		
High Cholesterol	Yes <input type="checkbox"/> No <input type="checkbox"/>		
High Blood Pressure	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Stroke or Blood Clots	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Substance abuse (alcohol, drugs)	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Thyroid disease	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Osteoporosis	Yes <input type="checkbox"/> No <input type="checkbox"/>		

### Lifestyle History

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

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

**Lifestyle History (continued from previous page)**

In the past month, have you drunk any alcohol or used other drugs? How many <b>days per month do you drink?</b> _____ How many <b>drinks on any given day?</b> _____ How often did you have <b>4 or more drinks per day in the last month?</b> _____	Yes <input type="checkbox"/> No <input type="checkbox"/>
Have you smoked any cigarettes in the past 3 months? If yes, list cigarettes per day _____	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do your friends have a problem with alcohol or other drug use?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Does your partner have a problem with alcohol or other drug use?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Are you feeling at all unsafe in any way in your relationship with your current partner or at home?	Yes <input type="checkbox"/> No <input type="checkbox"/>
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 <input type="checkbox"/> No <input type="checkbox"/>
In the past, have you had difficulties in your life due to alcohol or other drugs, including prescription medications?	Yes <input type="checkbox"/> No <input type="checkbox"/>

**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 Type:				
Shingles									
Details:									

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


Forms completed by Patient <input type="checkbox"/> Nurse <input type="checkbox"/> Provider <input type="checkbox"/> Other <input type="checkbox"/>	
Patient Signature: _____	Reviewed by: _____