

Directions to

A Woman's View

915 Tate Blvd SE
Hickory, NC 28602
(828) 345-0800

From I-77 going West on I-40

Take I-40 West to Exit #125 (Lenoir-Rhyne Blvd.)
Lenoir-Rhyne Blvd. North (right) to Tate Blvd.
Tate Blvd. East (right) one block (< 1/2 mile)
At 1st traffic light turn left onto 9th St. Ln.
Turn left again into Westover Park
Go to rear of building to the appropriate Suite.

From Hwy 321 going East on I-40

Take I-40 East to Exit #125 (Lenoir-Rhyne Blvd.)
Lenoir-Rhyne Blvd. North (left) to Tate Blvd.
Tate Blvd. East (right) one block (< 1/2 mile)
At 1st traffic light turn left onto 9th St. Ln.
Turn left again into Westover Park
Go to rear of building to the appropriate Suite.

From Fairgrove Church Road

Turn left onto Tate Blvd.
Go 3 miles (8th Light)
Turn right onto 9th St. Ln.
Turn immediately left into Westover Park
Go to rear of building to the appropriate Suite

Don't forget, we now occupy **four** separate Suites at Westover Park. Suite 162 is where you would see Dr. Lovin. Suite 170 is our Women's Health and Primary Care Clinic where you would see Dr. Bilhorn, Dr. Walsh, Dr. Gonzalez, Janese Trivette, Teri Herman, Paige Resor, and Diane Meyer. Suite 180 is our Obstetrical Suite and is where you would see Dr. Faruque, Dr. Miletich, Valerie Taylor, and Dr. Harraghy. Suite 164 is where you would go for a DEXA scan, bladder treatment, and for the weight loss program.

From Hwy 127 North (Viewmont)

Turn left on 1st Ave SW
Turn left at 2nd stop light (9th St. Lane)
Turn left again into Westover Park
Go to rear of building to Suite 170

If you run into any problems, please give us a call and we will help you find us.



A Woman's View

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. It also provides information about your rights as a patient of our practice and whom you may contact at our office to ask questions about our privacy practices.

By signing this form, you agree that you have had the opportunity to read our Notice of Privacy Practices.

I have been offered a copy of the Notice of Privacy Practices for A Woman's View, P.A.

Patient Name (Please Print)

Social Security Number

Signature of Patient (or patient's representative)

Date

A Woman's View

Patient Financial Responsibility

The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services rendered.

- Prompt payment allows us to control costs. Outstanding accounts cost both the patient and the practice time and money; therefore, all patients will be required to establish financial arrangements for payment of their account.
- It should be noted that your insurance coverage is an agreement between you and your insurer. It is your responsibility to remit payment for charges not covered by your carrier, and to ensure your carrier remits payment for your account.
- All insurance co-payments are due and payable at the time of service prior to being seen. There are no exceptions. This is in accordance with federal regulations.
- As a courtesy to you, if we are contracted with your insurance company, we will file claims with them. Once your insurance company has processed your claim, you are responsible for any balance due. If the insurance company later provides additional payments on your claim you will receive any appropriate refund promptly.
- If we do not have a contract with your insurance company, payment is due in full when services are rendered.
- Once your insurance company has processed your claim, you will receive a statement for services which is due and payable within thirty days of the statement date. If your payment is late, or if you have not made financial arrangements, we will mail you a reminder notice indicating a problem with your account. It is imperative that you contact us immediately upon receipt of such notice.
- It is your responsibility to understand your plan guidelines regarding providers and hospitals that your plan is contracted with because employers do occasionally change their insurance plans, even if they do not change insurance companies. It is a good idea to contact your plan prior to scheduling an appointment to make sure that your plan has not changed since your last visit.
- For your convenience, we accept Visa, MasterCard, Discover, American Express, check, or cash in payment for services. Please do not send cash in the mail. There is a \$25 service charge for checks that are returned.
- If you are experiencing a set of financial circumstances beyond your control, please call our practice and we will be happy to make special payment arrangements.
- If it is necessary for you to undergo surgery, we will help you determine which services your insurance company will cover and which fees you will be your responsibility. Payment options will be discussed with you prior to scheduling your surgery to alleviate any unnecessary concern.
- Failure to adhere to the above policies could result in your account being turned over to an outside collection agency. Any fees associated with this will also be your responsibility.
- There is an administration fee of up to \$35 or in accordance with applicable law, payable in advance, for you to receive a copy of your medical records. This fee may be waived if your records are sent directly to another physician. This fee does apply to records sent to your insurance company. Also, there is an administration fee of \$10, payable in advance, for us to complete more than one copy of a disability form following surgery.
- There is a charge of \$10, payable in advance, for completion of a physical form for work, school, or other reasons if it is not done at the time of your actual physical.
- Failure to show for an appointment or failure to give at least 24 hours notice of a cancellation may result in a \$25 "no show" fee.
- It is important that we have accurate insurance information for all our patients. It is likely that you will be asked to show your current card on each visit. If you fail to provide your card, you will be required to pay that day any anticipated charges for the visit. If you are able to provide the card at a later time, we will refund any covered fees and file with your insurance company.
- In order to provide quality care, it is crucial that we have current contact information, including insurance information. If you are unable to provide this, we will not continue to provide healthcare services for you.
- We do not accept Medicaid retroactively on past visits. You will be responsible for those charges.

A Woman's View firmly believes that a good doctor/patient relationship is based upon understanding and open communication. Our staff have been instructed to make every effort to assist you in managing your account. We hope to avoid any disagreement over payment for professional services by clearly defining our policies at the onset. If you have any questions concerning this policy or need any assistance with your account in the future, please contact us immediately.

I have read the above financial agreement and agree to abide by the terms set forth in it.

Patient Name

Date

A Woman's View

Patient Insurance Information

The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services rendered.

- It should be noted that your insurance coverage is an agreement between you and your insurer. It is your responsibility to remit payment for charges not covered by your carrier, and to ensure your carrier remits payment for your account.
- Diagnosis cannot be changed based on insurance coverage. If you are seen for a specific problem or type of visit, we are required by law to “code” the visit according to what we did, not according to your insurance coverage.
- If your insurance company denies payment for pre-existing conditions or verification for coverage (such as student status), payment will become your responsibility if you do not provide this information to your insurance company.
- All insurance co-payments are due and payable at the time of service prior to being seen. There are no exceptions. This is in accordance with federal regulations.
- As a courtesy to you, if we are contracted with your insurance company, we will file claims with them. Once your insurance company has processed your claim, you are responsible for any balance due. If the insurance company later provides additional payments on your claim you will receive any appropriate refund in a timely manner.
- If we do not have a contract with your insurance company, payment is due in full when services are rendered.
- Once your insurance company has processed your claim, you will receive a statement for services which is due and payable within thirty days of the statement date. If your payment is late, or if you have not made financial arrangements, we will mail you a reminder notice indicating a problem with your account. It is imperative that you contact us immediately upon receipt of such notice.
- It is your responsibility to understand your plan guidelines regarding providers and hospitals that your plan is contracted with because employers do occasionally change their insurance plans, even if they do not change insurance companies. It is a good idea to contact your plan prior to scheduling an appointment to make sure that your plan has not changed since your last visit.
- It is important that we have accurate insurance information for all our patients. It is likely that you will be asked to show your current card on each visit. If you fail to provide your card, you will be required to pay that day any anticipated charges for the visit. If you are able to provide the card at a later time, we will refund any covered fees and file with your insurance company.
- In order to provide quality care, it is crucial that we have current contact information, including insurance information. If you are unable to provide this, we will not continue to provide healthcare services for you.
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I have read the above financial agreement and agree to abide by the terms set forth in it.

Patient Name

Date

A Woman's View, PA

Please Use Black Ink Only

Social Security Number	Last Name	First Name	Maiden or Middle Initial
Mailing Address		City/State/Zip Code	Spouse
Home Phone	Date of Birth	Sex (M, F)	Race
Cell Phone	E-Mail Address	Marital Status Married Widowed Single Divorced Separated	Employment Full Time Part Time Retired None Student Full Time Part Time None

Employer Information

Employer/School Name		
Street Address	City/State/Zip Code	Business Phone Ext:

Name of Persons Responsible for Payment of Medical Bills

Social Security Number	Last Name	First Name	Maiden or Middle Name
Mailing Address		City/State/Zip Code	Employer
Business Phone	Home Phone	Cell Phone	Date of Birth
Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated		Employment Full Time Part Time Retired None Student	Relationship to insured Self Spouse Child Other

Insurance Information

Primary Insurance Company Name		Name of Policy Holder		Date of Birth
Employer	Social Security #	Policy #	Group #	Patient is Self Spouse Child
Secondary Insurance Company Name		Name of Policy Holder		Date of Birth
Employer	Social Security #	Policy #	Group #	Patient is Self Spouse Child

Emergency Contact Information

Contact in case of emergency	Relationship	Telephone
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Referral Information

Referred by	Relationship
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Consent for Treatment

I hereby give consent to A Woman's View to provide whatever treatment the assigned physician/provider may deem necessary to the patient named above.

I understand that I am responsible for payment of charges and that payment is due at the time of service. It is my responsibility to bill my insurance company unless A Woman's View is contracted with my insurance plan. I understand I am also responsible for noncovered services. In the event of hospital admission, I hereby assign insurance benefits, otherwise payable to me, to be paid directly to A Woman's View for professional fees and authorize release of information for insurance purposes.

I request payment of authorized Medicare benefits, contracted insurance plan and/or any other insurance benefits to be made either to me or on my behalf to A Woman's View for any services furnished to me by A Woman's View. I authorize any holder of medical information about me to release it to A Woman's View and its agents any information needed to determine these benefits payable for related services. I have been offered a copy of A Woman's View's Notice of Privacy Practices.

Signature of Patient

Signature of Guarantor

Date

Pharmacy _____

Previous MD/PCP _____

A Woman's View

New Patient History

Patient Name: _____ DOB: _____

Age: _____ Date: _____

Past Medical History: Please check any of the following conditions you have had:

Neuropsychiatric

- Depression
- Anxiety
- Eating disorder
- Stroke
- Seizures
- Migraines

Cardiovascular

- Heart murmur
- High blood pressure
- Heart attack
- Irregular heartbeat
- Rheumatic fever
- Anemia
- Palpitations
- Congestive Heart Failure

Endocrine/Rheum

- Diabetes
- Menopause
- Elevated cholesterol
- Thyroid disease
- Gout
- Arthritis
- Rheumatoid Arthritis
- Lupus
- Fibromyalgia

GI

- Hepatitis
- Heartburn
- Diverticulosis
- Hemorrhoids
- Ulcer
- Colitis/Crohn's Disease
- Irritable bowel
- Gallstones

Gynecological

- Pelvic Pain
- Herpes
- Gonorrhea
- Chlamydia
- Genital Warts
- HIV/AIDS

Pulmonary

- Asthma
- COPD
- TB

Cancer

- Breast
- Skin
- Colon
- Other

Other: _____

Obstetrical/Gynecological History

Last menstrual period(Month/Day/Year): _____

Age at which menses began: _____

Presently breastfeeding? _____ Yes No

Number of pregnancies: _____

Number of children: _____

Pregnancy Complications: _____

Number of miscarriages or abortions: _____

Current birth control method: _____

Have you had a hysterectomy? Yes No Do you have your ovaries? Yes No

Previous abnormal PAP smear? Yes No When? _____

Last PAP smear (Month/Year) _____ Normal? Yes No

Last Mammogram (Month/Year) _____ Normal? Yes No

Previous bone density (DEXA) scan? Yes No Year _____ Normal? Yes No

Previous Immunizations

_ MMR _ Hepatitis B _ Pneumovax _ Tetanus _ Other: _____

Have you had a colonoscopy? Yes No Year _____ Normal? _____

Have you ever required a blood transfusion? Yes No Year _____

Current Medications (Name/Strength in mg/How often)

Alternative Medicines/Vitamins/Supplements (Name/Strength in mg/How often)

Allergies to Medications

Hospitalizations/Surgeries

Please circle any of the following symptoms which you are experiencing:

General: Weight loss/gain Fever Chills Night sweats Poor appetite Low energy level

Eyes: Blurred vision Double vision Eye pain Floaters Flashing lights Spots

ENT: Hearing loss Ringing in ears Nosebleed Congestion Gum bleeding Difficulty swallowing

Resp: Shortness of breath Cough Blood in sputum Wheezing

CV: Chest pain Palpitations Pain in legs with walking

GI: Stomach pain Nausea Vomiting Diarrhea Constipation Blood in stool Black stool Heartburn

GU: Vaginal discharge Irregular periods Painful periods PMS Pelvic pain Abnormal bleeding Sores Warts

Painful urination Painful intercourse Incontinence Blood in urine

MSK: Joint pain Swelling Stiffness

Affected joints: Spine Shoulder Elbow Wrist Finger Hip Knee Ankle Toe

Neuro: Numbness Weakness Dizziness Fainting Tingling Headaches Seizures

Skin: Rash Changing mole Sore/skin ulcer that won't heal Itching

Psych: Depression Anxiety Hallucinations Suicidal thoughts Sleep disturbance Eating disorder

Endo: Hot/cold natured Excessive hunger Excessive Thirst Frequent urination Flushing

Allergy/Immuno: Frequent infections Runny eyes Hives Itchy eyes

Heme/Lymph: Prolonged bleeding Easy bruising Swollen glands

Do you have any medical problems that are not listed above? No Yes

If yes, please list them here: _____

Family History: Has anyone in your family (mother, father, sister, brother, children) had:

Heart Disease _____

Cancer _____ Type: _____

High blood pressure _____

Diabetes _____

Osteoporosis _____

Seizures _____

Thyroid disease _____

Bleeding disorder _____

Other _____

Social History and Lifestyle Issues

Marital Status: Single Married Divorced Widowed

Highest level of education: _____

Occupation _____

Cigarettes Do you smoke? Yes No Packs a day/#years smoked) _____ / _____

Alcohol _____ Drugs _____

Caffeine _____

Amount of exercise per week _____ And Type _____

Do you have a living will regarding end-of-life healthcare? Yes No

Patient's signature

Date