

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 1<sup>st</sup> traffic light turn left onto 9<sup>th</sup> 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 1<sup>st</sup> traffic light turn left onto 9<sup>th</sup> 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 (8<sup>th</sup> Light)  
Turn right onto 9<sup>th</sup> 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, Lisa Largent, Diane Meyer, and Jennifer Ferrara. Suite 180 is our Obstetrical Suite and is where you would see Dr. Faruque, Dr. Miletich, 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 1<sup>st</sup> Ave SW  
Turn left at 2<sup>nd</sup> stop light (9<sup>th</sup> 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.

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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.
- We do not accept Medicaid retroactively. 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.

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Patient Name

Date

# A Woman's View, PA

Welcome to our practice

Please help us serve you better by taking a few minutes to provide the following information

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

## Employer Information

Employer/School Name		
Street Address	City/State/Zip Code	Business Phone <span style="float: right;">Ext:</span>

## Name of Persons Responsible for Payment of Medical Bills

Social Security Number	Last Name	First Name	Maiden or Middle Name
Street Address		City/State/Zip Code	Employer
Business Phone	Home Phone	Cell Phone	Date of Birth
Marital Status Single   Married   Divorced   Separated		Employment 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

# *A Woman's View*

## PATIENT INTAKE HISTORY

NAME: \_\_\_\_\_

BIRTH DATE: \_\_\_/\_\_\_/\_\_\_

DATE: \_\_\_/\_\_\_/\_\_\_

REFERRED BY: \_\_\_\_\_

### REVIEW OF SYSTEMS

PLEASE CHECK (X) IF ANY OF THE FOLLOWING APPLY TO YOU NOW, IN THE PAST OR OFTEN			
	CURRENTLY	PAST	NOTES
<b>1. CONSTITUTIONAL</b>			
Weight loss	<input type="checkbox"/>	<input type="checkbox"/>	
Weight gain	<input type="checkbox"/>	<input type="checkbox"/>	
Fever	<input type="checkbox"/>	<input type="checkbox"/>	
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	
<b>2. EYES</b>			
Double vision	<input type="checkbox"/>	<input type="checkbox"/>	
Spots before eyes	<input type="checkbox"/>	<input type="checkbox"/>	
Vision changes	<input type="checkbox"/>	<input type="checkbox"/>	
<b>3. ENT/MOUTH</b>			
Ear aches	<input type="checkbox"/>	<input type="checkbox"/>	
Ringing in ears	<input type="checkbox"/>	<input type="checkbox"/>	
Sinus problems	<input type="checkbox"/>	<input type="checkbox"/>	
Sore throat	<input type="checkbox"/>	<input type="checkbox"/>	
Mouth sores	<input type="checkbox"/>	<input type="checkbox"/>	
Dental problems	<input type="checkbox"/>	<input type="checkbox"/>	
<b>4. CARDIOVASCULAR</b>			
Painful breathing	<input type="checkbox"/>	<input type="checkbox"/>	
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	
Difficult breathing on exertion	<input type="checkbox"/>	<input type="checkbox"/>	
Swelling of legs	<input type="checkbox"/>	<input type="checkbox"/>	
Palpitations of heart	<input type="checkbox"/>	<input type="checkbox"/>	
<b>5. RESPIRATORY</b>			
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	
Spitting up blood	<input type="checkbox"/>	<input type="checkbox"/>	
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	
Cough, chronic	<input type="checkbox"/>	<input type="checkbox"/>	
<b>6. GASTROINTESTINAL</b>			
Diarrhea, frequent	<input type="checkbox"/>	<input type="checkbox"/>	
Bloody stool	<input type="checkbox"/>	<input type="checkbox"/>	
Nausea/vomiting	<input type="checkbox"/>	<input type="checkbox"/>	
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	
<b>7. GENITOURINARY</b>			
Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>	
Pain with urination	<input type="checkbox"/>	<input type="checkbox"/>	
Urgency	<input type="checkbox"/>	<input type="checkbox"/>	
Frequency of urination	<input type="checkbox"/>	<input type="checkbox"/>	
Incomplete emptying	<input type="checkbox"/>	<input type="checkbox"/>	
Stress incontinence	<input type="checkbox"/>	<input type="checkbox"/>	
Abnormal periods	<input type="checkbox"/>	<input type="checkbox"/>	
Painful intercourse	<input type="checkbox"/>	<input type="checkbox"/>	
<b>8. MUSCULOSKELETAL</b>			
Muscle weakness	<input type="checkbox"/>	<input type="checkbox"/>	
<b>9. SKIN/BREAST</b>			
	CURRENTLY	PAST	
Pain in breast	<input type="checkbox"/>	<input type="checkbox"/>	
Discharge	<input type="checkbox"/>	<input type="checkbox"/>	
Masses	<input type="checkbox"/>	<input type="checkbox"/>	
Rash	<input type="checkbox"/>	<input type="checkbox"/>	
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	

<b>10. NEUROLOGICAL</b>		
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Numbness	<input type="checkbox"/>	<input type="checkbox"/>
Trouble walking	<input type="checkbox"/>	<input type="checkbox"/>
<b>11. PSYCHIATRIC</b>		
Depression	<input type="checkbox"/>	<input type="checkbox"/>
Crying, frequent	<input type="checkbox"/>	<input type="checkbox"/>
<b>12. ENDOCRINE</b>		
Dry skin	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal thirst	<input type="checkbox"/>	<input type="checkbox"/>
Hot flashes	<input type="checkbox"/>	<input type="checkbox"/>
<b>13. HEMATOLOGIC/LYMPHATIC</b>		
Bruises, frequent	<input type="checkbox"/>	<input type="checkbox"/>
Cuts do not stop bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Enlarged lymph nodes	<input type="checkbox"/>	<input type="checkbox"/>
<b>14. ALLERGIC/IMMUNOLOGIC</b>		
Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Drugs, other	<input type="checkbox"/>	<input type="checkbox"/>

PERSONAL PAST HISTORY

MAJOR ILLNESSES	YES	NO		Y E S	NO
Asthma			Cancer		
Pneumonia			Ulcers		
Chronic Lung Disease			Depression/anxiety		
Kidney Infections/stones			Anemia/Blood transfusions		
Tuberculosis			Seizures/convulsions/epilepsy		
Venereal Disease/Herpes			Bowel trouble		
Heart Trouble/murmur			Glaucoma		
Diabetes			Arthritis/joint pain		
High Blood Pressure			Fracture		
Stroke			Hepatitis/Yellow jaundice		
Rheumatic Fever			Thyroid Disease		
OPERATIONS/HOSPITALIZATIONS					
Reason			Date	Reason	Date
INJURIES/ILLNESSES					
Type			Date	Type	Date
LAST IMMUNIZATION OR TEST					
			Date		Date
Tetanus				Pneumonia	
Flu Shot				TB Skin Test	
OB/GYN HISTORY					
			Number		Number
Births				Abortions	
Miscarriages				Living children	

CURRENT MEDICATIONS			
Drug Name	Dosage	Drug Name	Dosage

FAMILY HISTORY

Illness	Yes	Relative	Illness	Yes	Relative
Diabetes			Drinking Problem		
Stroke			Breast Cancer		
Heart Disease			Colon Cancer		
High Blood Pressure			Ovarian Cancer		

SOCIAL HISTORY

Habits						
Smoking	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Packs per day _____	Years _____
Alcohol	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Drinks per day _____	Drinks per week _____
Drug Use	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>		
Seat Belt Use	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>		
Regular Exercise	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>		

  

Personal Profile								
Marital Status	Married	<input type="checkbox"/>	Single	<input type="checkbox"/>	Widowed	<input type="checkbox"/>	Divorced	<input type="checkbox"/>
Number of Living Children	_____							
Number of people in household	_____							
School Completed	High School	<input type="checkbox"/>	College	<input type="checkbox"/>	Graduate Degree	<input type="checkbox"/>	Other	<input type="checkbox"/>
Current or most recent job	_____							

Completed by: Patient  Office Nurse  Physician

Signature of patient: \_\_\_\_\_

Date reviewed by physician with patient: \_\_\_\_\_

Physician Signature: \_\_\_\_\_

Annual Review of History

Date reviewed: \_\_\_\_\_ Physician Signature: \_\_\_\_\_

Date reviewed: \_\_\_\_\_ Physician Signature: \_\_\_\_\_

Date reviewed: \_\_\_\_\_ Physician Signature: \_\_\_\_\_

Date reviewed: \_\_\_\_\_ Physician Signature: \_\_\_\_\_

# A Woman's View

## Important Telephone Numbers and Extensions

www.awomansview.com

Catawba Valley Imaging Mammogram ..... 828-326-3858  
Frye Mammogram Center ..... 828-315-7050

### GYN Phone Nurse for

Dr. Lovin, Dr. Bilhorn, Dr. Walsh, Teri Herman, NP

Lisa Largent, NP (test results, refills etc.)

*Chassidy Elder, RN\** ..... Direct #:828-345-6310  
Or ..... 828-345-0800 ext. 206

### Primary Care Phone Nurse for

Anne Gonzalez, MD

*Yna Compton* ..... 828-345-0800 ext. 243

Janese Trivette, NP

*Melissa Woodring* ..... 828-345-0800 ext. 329

Jennifer Ferrara, NP

*Whitney Reid* ..... 828-345-0800 ext. 220

Diane Meyer, NP

*Kim Ingle* ..... 828-345-0800 ext. 390

### OB-GYN Phone Nurse for Dr's Faruque, Harraghy, Miletich, and Valerie Taylor, CNM

*Olivia Krueger, RN* ..... 828-345-0800 ext. 386

### Clinical/Surgical Coordinator

*Angela Shook* ..... 828-345-0800 ext. 209

**Insurance questions/billing direct line** ..... 828-325-4961

*Heather Callahan*..... 828-345-0800 ext. 382

*Vicki Campbell* ..... 828-345-0800 ext. 223

**Appointments for all providers**..... 828-345-0800

*Kay Carter* ..... 828-345-0800 ext. 218

*Paige Anderson* ..... 828-345-0800 ext. 311

### Bladder Clinic

*Dianne Keller, RN*..... 828-345-0800 ext. 221

**Pure Reflection Spa for Wellness** ..... 828-345-1290

**Labcorp pap smear results**..... 888-567-8723

\*The nurses may be on the telephone with other patients or in the room with a provider so you may be asked to leave a message. If you need a refill on a prescription leave your name, date of birth, medication, pharmacy and a telephone number where you can be reached if they have any questions. Check with the pharmacy prior to calling back to see if the prescription has been refilled.

# A Woman's View

(828) 345-0800

915 Tate Blvd. SE, Suite 170, Hickory, NC 28602

Fax: (828) 345-0350

## Authorization for the Release of Medical Information

Patient Name: \_\_\_\_\_  
(Please Print) Last First Middle Maiden

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

I authorize \_\_\_\_\_ to release the following medical records to:

A Woman's View  
915 Tate Blvd. SE, Suite 170  
Hickory, NC 28602  
Phone: (828) 345-0800  
Fax: (828) 345-0350

The purpose of the use or disclosure is to establish or transfer medical care to A Woman's View.

Time period for medical records that are being released: From: \_\_\_\_\_ To: \_\_\_\_\_

### The patient or the patient's representative must read and initial the following statements:

I understand that this authorization will expire on \_\_\_\_\_ Initials \_\_\_\_\_

I understand that I may revoke this authorization at any time by notifying A Woman's View, P.A. in writing, but if I do it will not have an effect on any actions taken in reliance on my authorization before the practice received the revocation.

Initials \_\_\_\_\_

**NOTICE TO PATIENTS:** The patient or the patient's representative may inspect and/or copy the health information to be used or disclosed in accordance with A Woman's View policies. **You may refuse to sign this authorization.** A Woman's View, P.A. will not condition treatment or payment on your providing this authorization except in the specific circumstances allowed by the Privacy Rule.

I hereby authorize the use or disclosure of my individually identifiable health information as described above. I understand that this authorization is voluntary. I understand that when the information is used or disclosed, it may be subject to being redisclosed and may no longer be protected by federal privacy regulations.

Patient Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
(Please Print)

Signature: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Printed name of patient's representative, if applicable \_\_\_\_\_

Representative's Authority: \_\_\_\_\_