
PHILADELPHIA WOMEN'S
HEALTH & WELLNESS

New Patient Forms Packet

Dear New Patient,

Welcome to Philadelphia Women's Health & Wellness.

Our mission is to provide excellence in health and wellness care, to encourage the inner strength of all women. One Woman At A Time.

Prior to your visit, may we ask you to please print and complete the forms in this packet?

Kindly, bring the completed forms to your first appointment.

Doing this will help us to make your first visit a simple and relaxed experience.

If you have any questions, please do not hesitate to call 267-335-3152. Thank you.

To your health,

Drs Keen, Kohl, & Myers

New Patient Registration Form

Name: _____ DOB: _____

Cell: _____ Home: _____ Work:_____

Address: _____

_____

Email: _____

Emergency Contact

Name:_____ Phone: _____

Relationship: _____

Preferred Pharmacy

Name:_____ Phone: _____

Address: _____

_____

Alternate Pharmacy (if applicable)

Name:_____ Phone: _____

Address: _____

_____

PATIENTS RIGHTS AND RESPONSIBILITIES

CONFIDENTIALITY

It is the policy of **Philadelphia Women's Health & Wellness** to treat all patient information confidentially. This includes patient records and conversations. We will investigate any reported violation of this policy. If you have any questions, please ask a front desk representative for information. **Philadelphia Women's Health & Wellness** makes every effort to provide our patients with an environment, which is safe, private and respectful of our patient's needs. If you have a complaint about our services, facilities or staff, we want to hear from you. We will do everything we can to see that your experience with us is professional in every way.

ISSUES OF CARE

Philadelphia Women's Health & Wellness is committed to your participation in care decisions. As a client, you have the right to ask questions and receive answers regarding the course of clinical care recommended by any of our health providers, including discontinuing care. We urge you to follow the healthcare directions given to you by our providers. However, if you have any doubts or concerns, or if you question the care prescribed by our providers, please ask.

PATIENT RIGHTS

1. The patient has the right to receive information from health providers and to discuss the benefits, risks, and costs of appropriate treatment alternatives. Patients should receive guidance from their health providers as to the optimal course of action. Patients are also entitled to obtain copies or summaries of their medical records, to have their questions answered, to be advised of potential conflicts of interest that their health providers might have, and to receive independent professional opinions.
2. The patient has the right to make decisions regarding the health care that is recommended by his or her health provider. Accordingly, patients may accept or refuse any recommended medical treatment.
3. The patient has the right to courtesy, respect, dignity, responsiveness, and timely attention to his or her needs, regardless of race, religion, ethnic or national origin, gender, age, sexual orientation, or disability.
4. The patient has the right to confidentiality. The health provider should not reveal confidential communications or information without the consent of the patient, unless provided for by law or by the need to protect the welfare of the individual or the public interest.
5. The patient has the right to continuity of health care. The health provider has an obligation to cooperate in the coordination of medically indicated care with other health providers treating the patient. The health provider may discontinue care provided they give the patient reasonable assistance and direction, and sufficient opportunity to make alternative arrangements.

PATIENT RESPONSIBILITIES

1. Good communication is essential to a successful health provider-patient relationship. To the extent possible, patients have a responsibility to be truthful and to express their concerns clearly to their health providers.

2. Patients have a responsibility to provide a complete medical history, to the extent possible, including information about past illnesses, medications, hospitalizations, family history of illness and other matters relating to present health.

3. Patients have a responsibility to request information or clarification about their health status or treatment when they do not fully understand what has been described.

4. Once patients and health providers agree upon the goals of therapy, patients have a responsibility to cooperate with the treatment plan. Compliance with health provider instructions is often essential to public and individual safety. Patients also have a responsibility to disclose whether previously agreed-
upon treatments are being followed and to indicate when they would like to reconsider the treatment plan.

5. Patients should also have an active interest in the effects of their conduct on others and refrain from behavior that unreasonably places the health of others at risk.

_____ _____
Patient Name Date

_____ _____
Date of Birth Chart Number

Acknowledgement of Notice of Privacy Practices (NPP)

A Notice of Privacy Practices (NPP) is provided to all patients. The Notice of Privacy Practices identifies: 1) how medical information about you may be used or disclosed; 2) your rights to access your medical information, amend your medical information, request an accounting of disclosures of your medical information, and request additional restrictions on our uses and disclosures of that information; 3) your rights to complain if you believe your privacy rights have been violated; and 4) our responsibilities for maintaining the privacy of your medical information.

The undersigned certifies that he/she has read the foregoing, received a copy of the Notice of Privacy Practices and is the patient, or the patient's personal representative.

_____ _____

Name of Patient Signature of Patient

_____/ _____/ _____

Date Signed

_____ _____

Name of Patient's Personal Representative Signature of Patient's Personal Representative

_____/ _____/ _____

Date Signed

_____

FOR INTERNAL USE ONLY

_____ _____

Name of Employee Signature of Employee

If applicable, reason patient's written acknowledgement could not be obtained

- Patient was unable to sign.
- Patient refused to sign
- Other_____

____/____/____ (Date: As noted on NPP)

PHILADELPHIA WOMEN'S HEALTH & WELLNESS

CONSENT TO LEAVE MESSAGES /SHARE INFORMATION WITH FAMILY & FRIENDS

I understand that my healthcare information is protected. I understand that, in order for us to leave detailed messages containing specific dental information on my voicemail or answering machine, I need to give permission for us to do so.

Consent for Leaving Messages

I give my permission for messages to be left on my phone number(s) below:

( ) Cell # _____ **( )** Home # _____ **( )** Work #_____

( ) I prefer not to have voice mail messages from the office

Regarding the following:

( ) Appointment Reminders/Changes **( )** Account Payments/Balances **( )** Cost Estimates

( ) Needed Treatment/Completed Treatment

Consent for Shared Information with Family & Friends

Under the HIPAA Privacy Law we are permitted and we may make a professional judgment that certain disclosures are in your best interests even without this signature. I understand that information is limited to verbal discussions and that no paper copies of my protected healthcare information will be provided without my signature on a Release of Information Form.

The name(s) listed below are family members or friends to whom I grant permission for PWH&W and their representatives at our office to verbally discuss my care using their best judgment and grant them permission to disclose dental information that is relevant to my care or relevant for payment. **Yes** **No**

	NAME	RELATIONSHIP	PHONE NUMBER
1			
2			

Regarding the following:
( ) Appointment Reminders/Changes **( )** Account Payments/Balances **( )** Cost Estimates

( ) Needed Treatment/Completed Treatment

It will be my responsibility to keep this information up to date, as I recognize that relationships and friendships may change over time. This consent will be considered valid until such time that I revoke it in writing. I reserve the right to revoke it at any time.

_____ _____ _____

Printed Name (Patient/Parent) Signature (Patient/Parent) Date

Authorization to Release Medical Records

Name of Patient _____ Date(s) of Service _____

Date of Birth _____ Social Security Number _____

I, the undersigned, authorize the release of, or request access to the information specified below from the medical record(s) of the above name patient.

PATIENT INFORMATION IS NEEDED FOR:

Continuing Medical Care	Military	Social Security/Disability
Insurance	Personal Use	Legal Purposes
School: _____		Other: _____

INFORMATION TO BE RELEASED OR ACCESSED:

History & Physical	Consultation Report	Emergency Room Record
Operative Reports	Discharge/Death Summary	Face Sheet
Lab/Path Reports	X-Ray Reports/Images	Other: _____

The above information may be released (specify name or title of the individual or the name of the organization to which records are to be released and the appropriate address):

TO: Philadelphia Women's Health & Wellness 267-335-3152

(Doctor, Hospital, Attorney, Insurance Company, Self, etc.) Phone Number

3300 Henry Avenue, Suite 101 Philadelphia, PA 19129 833-518-1220

Address (Street, City, State and ZIP) Fax Number

FROM:

_____

(Doctor, Hospital, Attorney, Insurance Company, Self, etc.) Phone Number

_____

Address (Street, City, State and ZIP)

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected. I understand that the specified information to be released may include but is not limited to history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV and AIDS.

I understand that my treatment or payment for my treatment cannot be conditioned on the signing of this authorization. I also understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization. The authorization will expire six (6) months from the date of my signature, unless I revoke the authorization prior to that time (See CFR §164.508(c)(2)(i-iii).

Date: _____ Signature: _____

Patient or Legally Authorized Representative

_____

Printed Name of Patient or Legally Authorized Representative

_____

Relationship to Patient