

2695 Ulmerton Rd.
Clearwater, FL 33762
Phone: (727) 540-0414
Fax: (727) 540-0672



Today's Date: _____

JENNIFER S. HAYES DO, FACOOG

Patient Name: _____
Last First M.I.

Home Address: _____
Street Apt# City State Zip

Birth Date: ____/____/____ Age: ____ SS # _____ - ____ - ____ Drivers License # _____

E-mail: _____

Home # (____) _____ Cell # (____) _____ Work # (____) _____

Preferred Contact (CIRCLE): Home Work Cell E-mail

Employer: _____ Occupation: _____

Employer Address: _____ Phone # (____) _____

Marital Status: Single Married Partnered Separated Divorced Widowed

Spouse Name: _____ Phone # (____) _____

Employer: _____ Occupation: _____

Emergency Contact: _____ Phone # (____) _____

Primary Care Physician: _____ Phone # (____) _____

HOW DID YOU HEAR ABOUT US?

- You've Been a Patient of Dr. Hayes
- In-Office – Current Patient/Staff Member _____
- Friend / Family Who may we thank? _____
- Physician / Healthcare Provider Who may we thank? _____
- Internet – Google/Yahoo/OnlineSurgery.com/Other Site: _____
- Media / TV / Lecture / Seminar _____
- Print Advertising _____

RELEASE OF INFORMATION: *We will only discuss your protected health information (PHI) with you unless you authorize us to discuss it with someone else. Please list below the name(s) of individuals you authorize our office to discuss your care with. If this list changes, please notify us in writing.*

I acknowledge that I have received a copy of Visionary Centre for Women's "Notice of Privacy Practices":.
I have read and understand the above and agree to comply.

Patient's Signature: _____ Date: ____/____/____

REVIEW OF SYSTEMS

Please check any problems you are currently having.

1. **General:** fever chills weight loss weight gain fatigue insomnia
2. **Eyes, Ear, Nose & Throat:** vision changes glasses or contacts headache
 hearing loss sinusitis
3. **Cardiovascular:** swelling of legs chest pain dizzy spells fainting
 difficulty breathing with exertion rapid hart beat irregular heartbeat
4. **Respiratory:** shortness of breath wheezing cough coughing up blood
5. **Gastrointestinal:** constipation diarrhea bloody stool nausea vomiting
 indigestion fecal incontinence flatulence
6. **Genitourinary:** burning with urination night time urination frequent urination
 trouble emptying your bladder leaking urine blood in urine infertility
7. **Musculoskeletal:** muscle weakness muscle pain joint pain back pain
8. **Skin:** dry rash itch ulcers pigmented lesions change in moles
9. **Breasts:** pain lump nipple discharge
10. **Neurologic:** fainting seizures numbness severe memory problems migraine
 headaches trouble walking ringing in ears
11. **Psychiatric:** anxiety depression crying spells mood swings
12. **Endocrine:** hair loss heat or cold intolerance excessive sweating excessive thirst
13. **Hematologic:** bleeding bruising swollen lymph nodes

PERSONAL PAST HISTORY

- | | | |
|---|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diets | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fibroids | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Blood Clots (legs/Lungs) | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Blood Transfusions | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Bowel Problems | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Reflux |
| <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Herpes or Genital Warts | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Cancer (location _____) | <input type="checkbox"/> HIV (known exposure) | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Chlamydia or Gonorrhea | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Syphilis |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Infertility | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Tuberculosis |

SURGICAL HISTORY

List all Surgeries: _____

List all Hospitalizations: _____

HEALTH

Screenings	Date of last Pap? _____ Last mammogram? _____ Last bone density? _____
	Have you ever had abnormal Pap? <input type="checkbox"/> yes <input type="checkbox"/> no Last Colonoscopy? _____
Exercise	<input type="checkbox"/> Sedentary (no exercise)
	<input type="checkbox"/> Mild exercise (i.e., climb stairs, walk 3 block, golf)
	<input type="checkbox"/> Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)
	<input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation 4x/week for 30 min.)
Diet	Are you dieting? <input type="checkbox"/> yes <input type="checkbox"/> no Describe _____
	Are you on a physician prescribed medical diet? <input type="checkbox"/> yes <input type="checkbox"/> no Which one? _____
	# of meals you eat in an average day? _____ Glasses of water per day? _____
Caffeine	<input type="checkbox"/> None <input type="checkbox"/> Coffee <input type="checkbox"/> Tea <input type="checkbox"/> Soda <input type="checkbox"/> None <input type="checkbox"/> Energy Drink
	# of cups or cans a day? _____
Alcohol	Do you drink alcohol? <input type="checkbox"/> yes <input type="checkbox"/> no
	# of glasses/cans per week? _____
Tobacco	Do you use tobacco? <input type="checkbox"/> yes <input type="checkbox"/> no # cigarettes per day? _____ # of years? _____
	or # of years quit? _____
Drugs	Do you currently use recreational or street drugs? <input type="checkbox"/> yes <input type="checkbox"/> no
Vital Stats	Height _____ Current Weight _____ Maximum Weight _____

List your current **Prescription Medications, Herbs, Vitamins**, appetite suppressants, over-the-counter meds

Name the Drug	Strength	Frequency Taken

List all **Allergies:** _____

FAMILY HISTORY

Does anyone in your family have any of the following (check and list relative)

- | | |
|--|---|
| <input type="checkbox"/> Arthritis (Lupus) _____ | <input type="checkbox"/> Ovarian Cancer _____ |
| <input type="checkbox"/> Blood Clots _____ | <input type="checkbox"/> Kidney Disease _____ |
| <input type="checkbox"/> Breast Cancer _____ | <input type="checkbox"/> Osteoporosis _____ |
| <input type="checkbox"/> Colon Cancer _____ | <input type="checkbox"/> Seizures _____ |
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Stroke _____ |
| <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> Uterine Cancer _____ |
| <input type="checkbox"/> High Blood Pressure _____ | |

Mother: Age _____ If deceased, cause of death and age _____

Father: Age _____ If deceased, cause of death and age _____

OBSTETRICAL HISTORY

List ALL births, ectopics, miscarriages and terminations:

Birth Year	Birth Weight	Baby's Sex	Type of Delivery	Complications

UROGYN HISTORY

Age at onset of menstruation? _____ First day of last menses? _____

Heavy periods, irregularity, spotting, pain, or discharge? _____

Period every _____ days? Length of periods? _____

Any changes in your period? _____

Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?

yes no _____

Are you currently sexually active? yes no Libido issues? _____

What type of contraception are you using? _____ # of lifetime sexual partners? _____

Any hot flashes or sweating at night? yes no Insomnia? yes no

Any Hair loss? yes no Energy/Vitality issues? yes no

Experienced any recent breast tenderness, lumps, or nipple discharge? yes no

Any problems with control of urination? yes no _____

Any discomfort or loss of sensation with intercourse? yes no _____

Any vaginal dryness, discharge, irritation or odor? yes no _____

Ever have kidney infection? yes no

Bladder infection? yes no

INSURANCE INFORMATION:

Primary Insurance Company Name: _____

Address: _____ Phone: (_____) _____

Insured Name: _____ Employer: _____

Policy Number: _____ Group Number: _____

Co-pay Amount: \$ _____ or Yearly Deductible: \$ _____

Secondary Insurance Company Name:

Address: _____ Phone: (_____) _____

Insured Name: _____ Employer: _____

Policy Number: _____ Group Number: _____

Co-pay Amount: \$ _____ or Yearly Deductible: \$ _____

Payment/Insurance Authorization and Assignment:

For situations in which I can use my insurance for payment, I hereby authorize Visionary Centre for Women to furnish all information to insurance carriers concerning my illness, and/or treatments, and I hereby assign to the physician all payments for medical services rendered to myself or my dependents. I understand any cosmetic procedures performed by Visionary Centre for Women are not covered by insurance and payment in full is required prior to any surgical procedure.

I understand that I am responsible for any amount not covered by insurance; this includes any course of treatment that is not a covered benefit (this includes HMO products). I understand that I am responsible for notifying Visionary Centre for Women of any changes in my insurance coverage. If I am delinquent in updating this information and the charges are denied, I understand that I will be responsible for these charges.

Patient Name: (please print) _____

Patient's Signature: _____ Date: ____/____/____

FINANCIAL POLICY

Welcome to our practice. We strive to provide you with excellent medical care and our goal is to make your visits as comfortable as possible.

- 1. Insurance.** We participate in most insurance plans, including Medicare. If you are not insured, or not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
- 2. Co-payments and deductibles.** All co-payments must be paid before or at the time of service. All deductibles must be paid when the amount is known. This arrangement is part of your contract with your insurance company. This fee is your responsibility. We cannot guarantee the deductible amount since it varies among patients and their plans and what services have been accessed in the recent past. It is best to call your insurance company.
- 3. Non-covered services.** Please be aware that some-and perhaps all-of the services you receive may be non-covered, considered investigational by some health plans, or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.
- 4. Proof of insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
- 5. Claims submission.** As a courtesy to you, we will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract. It is your responsibility to ask your plan what is covered and what is not covered.
- 6. Coverage.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 90 days, the balance will automatically be billed to you.
- 7. Nonpayment.** If your account is over 90 days past due, you will receive a letter stating that you have 30 days to pay your account in full. Partial payments will not be accepted unless prior arrangements have been made. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During the 30 day period, our physician will only be able to treat you on an emergency basis.
- 8. Recurrent missed appointments.** We may charge a \$25 fee for recurrent missed appointments not canceled within 24 hrs. These charges will be your responsibility.
- 9. Bounced checks.** Please be advised there is a \$25 fee for any bounced or returned checks.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines.

Signature of patient or responsible party _____ Date _____

Print Name _____

NOTICE OF PRIVACY PRACTICES

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.

How we may use and disclose your health information. We use health information about you for treatment, to get paid for treatment, for administrative purposes, and to evaluate the quality of care that you receive. For example, your health information may be shared with other providers to whom you are referred. Information may be shared by paper, mail, electronic mail, fax, or other methods. We may use or disclose your health information without your authorization for several reasons. But beyond those situations, we will ask for your written authorization before using or disclosing your health information. If you sign an authorization to disclose information, you can later revoke it to stop any future uses and disclosures.

Your rights. In most cases, you have the right to look at or get a copy of your health information that we use to make decisions about you. If you request copies, we may charge you a cost-based fee. You also have the right to request a list of certain types of disclosures of your information that we have made. If you believe your health information is incorrect or information is missing, you have the right to request that we correct the existing information or add the missing information.

Our legal duty. We are required by law to protect the privacy of your health information, provide this notice about our privacy practices, follow the privacy practices that are described in this notice, and seek your acknowledgment of receipt of this notice. We may change our privacy policies any time. Before we make a significant change in our policies, we will change our notice and post the new notice in the waiting area. You can also request a copy of our notice at any time. For more information about our privacy policies, contact the person listed below.

Privacy complaints. If you are concerned that we have violated your privacy rights, our privacy policies, or if you disagree with a decision we made about access to your health information, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request.

If you have questions please contact: Maria Kinzer, RN
c/o Visionary Centre for Women
2695 Ulmerton Rd., Clearwater, FL 33762

Acknowledgment of receipt of Notice of Privacy Practices: Please sign and print your name and provide the date, below, to acknowledge that you have received this Notice of Privacy Practices.

Name of Patient

Signature of Patient

Date / Time

PATIENT RIGHTS & RESPONSIBILITIES

You Have The Right:

- To be treated with respect, consideration and dignity, without discrimination on the basis of race, color, sex, religion, or national origin.
- To know the policy on rights and responsibilities you have as a patient.
- To participate in decisions involving your health care; to be assisted in the development of advance directives, and to know and take responsibility for the consequences of refusing treatment or not complying with therapy.
- To receive services in a safe and clean environment.
- To privacy and confidentiality and to approve or refuse the release of your medical records, except when release is required.
- To receive information concerning your diagnosis, treatments, and prognosis; and to accept or refuse treatment after full information is given.
- To know what provisions are available for after hours and emergency coverage; and to have access to an interpreter as needed in order to understand explanations.
- To know the fees for services provided and the policies regarding the payment of fees.
- To be free from abuse or neglect; to access protective services.
- To be referred to specialists and other professionals when needed and to change physicians if you are not satisfied and if other qualified physicians are available.
- To voice a compliment or complaint by calling (727) 540-0414 or fax: (727) 540-0672 or e-mail: drjenniferhayes@gmail.com

You Have The Responsibility:

- To provide, to the best of your knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to your health.
- To follow the treatment plan recommended by the practitioner responsible for your care; and for your actions if you refuse treatment or do not follow the practitioner's instructions.
- To keep appointments and, when unable to do so for any reason, to notify our office within 24 hrs.
- To ensure that the financial obligations of your health care are fulfilled as promptly as possible.
- To be considerate of the rights of other patients and personnel.
- To be respectful of the property of others.
- To ask for clarification when explanations regarding your treatment have not been given to your satisfaction.

ABOUT ADVANCE DIRECTIVES

Upon registration, we will ask you if you have an advance directive. An advance directive is a written document which communicates your health care wishes clearly.

There are two types of advance directives:

A Durable Power of Attorney for Health Care - is a document that allows you to designate another person (known as a proxy agent) who is at least 18 years of age to make medical decisions for you in the event you are unable to do so. These decisions may include, but are not limited to, the withholding or withdrawal of life prolonging procedures.

A Living Will or Health Care Directive - is a document that allows you to state in advance your wishes regarding the use of certain medical procedures and treatments and becomes effective when you are unable to make your own decisions and can no longer communicate such decisions. It serves as a guide to your family or the person you name as your agent.

Name of Patient

Signature of Patient

Date Time

Name of Legal Authorized Person

Signature of Legal Authorized Person

Date Time

Name of Witness

Signature of Witness

Date Time