THE EINHAUS GROUP FOR WOMEN'S HEALTH (EGFWH) --- www.einhausgroup.com **REFERRED BY:** ________________

Patient Information:

FULL NAME: First ________________________ Last ________________________ MI _____ **Marital Status:** S M D W

SOC SEC NUMBER: _________ - ______ - _________ **DATE OF BIRTH:** ______ / _______ / ________ **EMPLOYER:** ____________________

ETHNICITY: NON-HISPANIC _____ HISPANIC _____ PREF LANGUAGE: _______________ RACE ____________ GENDER: M F

Contact Information:

ADDRESS: ____ **HOME PHONE:** ______________________________

____ **WORK PHONE:** ______________________________

____ **CELL / MOBILE PHONE:** ______________________________

EMAIL ADDRESS: ____

Provider Information:

PRIMARY CARE PHYSICIAN: _____________________________ **REFERRING PHYSICIAN:** ______________________________

Guarantor Information (If patient is under 18 years old):

GUARANTOR NAME: _________________________________ **ADDRESS:** ____

PATIENT'S RELATIONSHIP TO GUARANTOR: ____

SPOUSE CHILD OTHER ____

Insurance Information:

PRIMARY INSURANCE NAME: ________________________ **SECONDARY INSURANCE NAME**: _________________________________

INSURED FULL NAME: ______________________________ **INSURED FULL NAME**: ____

INSURED SS#: ____ **INSURED SS#**: ____

INSURED DOB: _______________________________________ **INSURED DOB**: ____

INSURED GENDER: [ ] MALE [ ] FEMALE **INSURED GENDER**: [ ] MALE [ ] FEMALE

POLICY# / RID#: _____________________________________ **POLICY# / RID#**: ____

GROUP#: ____ **GROUP#**: ____

EFFECTIVE START DATE: ___________________________ **EFFECTIVE START DATE**: _______________________________________

EMPLOYER: ____ **EMPLOYER**: ____

Emergency Contact Information:

NAME: __________________________________ ADDRESS: ____

PHONE: _________________________________ RELATIONSHIP TO PATIENT: ____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION AND ASSIGNMENT OF INSURANCE BENEFITS

I authorize the release of any medical information necessary to process my insurance claim(s) and assign all medical and/or surgical benefits including major medical benefits, liability, auto, accident, Worker's Comp. etc., to which I am entitled, to **The Einhaus Group for Women's Health, (EGFWH) Kathryn B. Einhaus, M.D.** This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered valid as an original. Even though I have provided all of my insurance information, I understand that I may be financially responsible for any balance not covered by my insurance. I agree to provide my most current insurance information and if any bills are not paid by insurance because of outdated or inaccurate information, I agree to pay my entire bill in full – even though the bill might have been paid by insurance had I provided the correct information.

FINANCIAL AGREEMENT

All EGFWH account balances are due at the time of service. All past-due account balances may be assessed a LATE PAYMENT FEE equal to 18% per annum on the delinquent balance. A LATE PAYMENT FEE can be avoided by paying the account balance within 30 days of the mailing of the patient statement. Subject to such limitation as may be imposed by applicable law, if I have not made payment on my account as required, my account may be sent to an attorney or collection agency for collection, I will pay the reasonable fees of such attorney or collection agency, and all court costs to the extent provided by law as well as my total outstanding bill. No waiver by The EGFWH or any default hereunder shall constitute a waiver of any other default. The construction and enforcement of this Agreement shall be governed by the State of Indiana. Any provision of this agreement that may be prohibited by law shall be ineffective only to the extent of such prohibition. From time to time, The EGFWH may amend this Agreement by giving of such notice, if any, as may be required by applicable law. The EGFWH may assign the Agreement, or it's right hereunder, without notice to me.

CONSENT TO CARE

I request and give consent to Dr Einhaus, the nurse practitioners, their associates and assistants who may provide me medical care to perform such medical-surgical care, tests, procedures, and other necessary services as well as provide drugs and supplies as they consider necessary or beneficial for my health and well being. I acknowledge that no representations, warranties or guarantees as to the results or cures have been made to me or relied upon by me. In addition, I understand there may be adverse effects or complications from some treatments/procedures/drugs, etc.

Check all that apply: I agree to be contacted at: ______Home ______Work ______Cell ______EMAIL

Signature of Responsible Party: ____ Date:____________________________

The Einhaus Group for Women's Health **(June 1, 2011)**

HIPAA PRIVACY RECEIPT ACKNOWLEDGEMENT

Date: Month ________ Day _______ Year ________ # __________

The Einhaus Group for Women's Health "Notice of Privacy Practices" has been offered to me. It is available from the front desk of the EGFWH as well as on the website (www.einhausgroup.com). I understand I have the right to review the "Notice of Privacy Practices" prior to signing this document. By signing this document, I acknowledge **my receipt of and my agreement with and understanding of the above mentioned privacy practices**.

The Einhaus Group for Women's Health reserves the right to change the privacy practices that are described in the Notice of Privacy Practices.

Updated "Notice of Privacy Practices" is available at the front desk or on the website.

______________________________	______________________________
Printed Name of Patient	Printed Name of Personal Representative
______________________________	______________________________
Signature of Patient	Signature of Personal Representative
______________	______________________________
Patient Date of Birth	Description of Personal Reps. Authority
	☐ Check if the patient is a minor

I authorize the following individuals to have access to my Protected Health Information (PHI):

Name	Relationship	Date of Birth	Phone Number
________________	___________	__________	_____________
________________	___________	__________	_____________
________________	___________	__________	_____________
________________	___________	__________	_____________

Patient Signature: ____

For authorization to release PHI to the above listed individuals.

OFFICE USE ONLY

The above named patient or personal representative of the patient was given The Einhaus Group for Women's Health Notice of Privacy Practices on the date indicated, but either refused to sign the acknowledgement or did not return the acknowledgement.

____

Signature and Title of person providing the "Patient Notice of Privacy"

Forward this document to be scanned

THE EINHAUS GROUP FOR WOMEN`S HEALTH

Obstetrics & Gynecology

10215 Auburn Park Drive
FORT WAYNE IN 46825

****Please indicate any condition that you have experienced within the last month****

Patient Name: ______________________________ **Date of Birth:** ______________

1. Consititutional

YES	NO	
____	____	Weight loss
____	____	Weight gain
____	____	Fever
____	____	Fatigue

2. Eyes

YES	NO	
____	____	Vision changes
____	____	Glasses/Contacts

3. ENT/Mouth

YES	NO	
____	____	Ulcers
____	____	Sinusitis
____	____	Ears ringing
____	____	Trouble swallowing
____	____	Chronic sore throat
____	____	Chronic hoarseness

4. Cardiovascular

YES	NO	
____	____	Trouble breathing
____	____	Chest pain
____	____	Swelling
____	____	Palpitations

5. Respiratory

YES	NO	
____	____	Wheezing
____	____	Coughing blood
____	____	Cough
____	____	Out of breath without exertion
____	____	Out of breath walking up-hill
____	____	Out of breath walking, level ground

6. Gastrointestinal

YES	NO	
____	____	Diarrhea
____	____	Bloody stool
____	____	Nausea/Vomiting
____	____	Bowel movements less than 3 per week
____	____	Excessive bowel gas

7. Genitourinary

YES	NO	
____	____	Blood in urine
____	____	Painful urination
____	____	Urgency
____	____	Frequency
____	____	Incomplete emptying
____	____	Lose of urine with cough, sneeze, laugh, etc.
____	____	Abnormal bleeding
____	____	Painful intercourse

8. Musculoskeletal

YES	NO	
____	____	Muscle weakness
____	____	Joint pain

9. Skin/Breast

YES	NO	
____	____	Breast pain
____	____	Breast discharge
____	____	Masses
____	____	Rash
____	____	Ulcers

10. Neurological

YES	NO	
____	____	headaches
____	____	Fainting
____	____	Seizures
____	____	Numbness
____	____	Trouble walking

11. Psychiatric

YES	NO	
____	____	Depression
____	____	Crying

12. Endocrine

YES	NO	
____	____	Diabetes
____	____	Hypothyroid
____	____	Hyperthyroid
____	____	Hot flashes

13. Hemat/lymph

YES	NO	
____	____	Bleeding
____	____	Swollen lymphs
____	____	Bruises

14. Allergic/Immuno

YES	NO	
____	____	Drug allergies
____	____	Latex allergies

Comments: ______________________________

Patient Signature ______________________________ Date: ______________

Reviewed by: ________ Date ________ Reviewed by: ________ Date: ________ Reviewed by: ________ Date ________