Hello and Welcome to ***Omnia Women's Health Center!***

We would like to take this opportunity to thank you for choosing us to participate in your care. We look forward to building and establishing this new relationship with you. We are excited to guide you along this healthcare journey and come up with a comprehensive care plan that is just right for you.

Our office is open Monday through Friday from the hours of 9:00 am to 4:30 pm. If there is an emergency that cannot wait until the next morning, we are also available after hours through our on-call service. The after-hours line is for phone consultation only. We do not make house calls. We pride ourselves on the time we spend with our patients, so scheduling ahead of time is a requirement in our office. We provide several different ways to book an appointment with us (online, phone and in person).

We are women's health providers specially trained to manage the female pelvis and all its complexities. Since we are a specialty office, there may be certain aspects of your health that we do not acutely manage. But we have several friends in the surrounding areas who have partnered with us in this healthcare arena to provide any and all care that you might need.

Before you schedule your first appointment, please check with your insurance company to ensure that the service we provide will be covered under your health plan. And in the unfortunate instance that they do not, we encourage you to write your insurance company in support of them providing coverage to you at our wonderful facility!

If you are ever in need of in hospital care. We are currently able to see patients at **Banner Estrella Medical Center located on 9201 W Thomas Road in Phoenix Arizona.**

Please take a moment to fill out your new patient registration forms. Please bring your health insurance card and a photo ID with you to your first appointment.

We look forward to building this relationship with you and we thank you for entrusting us with your care!

Sincerely,

Omnia Women's Health Center

New GYN Patient Intake Form

Please complete this brief form to assist me in providing you with the best care possible.
This form will be added to your medical record.

Todays Date:_____

Name:_____
Preferred Name:_____
Date of Birth:_____ Phone #:_____
Emergency Contact:_____ EC phone #:_____
Home Address:_____
Email Address:_____
Preferred Pharmacy and Cross Streets:_____
How did you hear about us?_____
Reason for Visit:_____

SEXUAL IDENTITY

What is your sexual orientation?	**What is your gender identity?**
○ Straight/Heterosexual	○ Female
○ Lesbian/Gay	○ Transgender woman
○ Bisexual	○ Male
○ Other:_____	○ Transgender male
○ Decline to answer	○ Gender queer/gender non-conforming
	○ Decline to answer

WELLNESS HISTORY

Last pap: _____ Abnormal pap? (Circle One) **Y N, If yes When?**_____
Last Mammogram: _____ Abnormal Mammogram (Circle One) **Y N, If yes When?**_____
Last Colonoscopy: _____ Last Pelvic Ultrasound: _____
Last Bone Density: _____

GYNECOLOGICAL HISTORY

Last menstrual Period: _____
I first started my periods at age _____. My periods usually occur every _____ days, and last for _____ days.
My periods are (circle one) **Light/Medium/Heavy**, and I experience (circle one) **Pain/no Pain** with my periods.
I went into menopause at age _____

Do you have a history of:

- ○ Ovarian Cysts
- ○ Endometriosis
- ○ Fibroids
- ○ Chlamydia/Gonorrhea
- ○ Trichomonas
- ○ Genital Warts/HPV
- ○ HIV
- ○ Syphilis
- ○ Hepatitis
- ○ Herpes
- ○ Osteoporosis

Are you currently sexually active? (Circle One) **Y N** Any Issues? _____
Have you ever used contraceptives (Circle One) **Y N** Current birth control method?_____
Have you ever been on hormone replacement therapy? (Circle One) **Y N**

OBSTETRICAL HISTORY

Multiples:_____ Miscarriages:_____ Abortions:____ Ectopic Pregnancies:____ Live Births:_____

Year	Gender (m/f)	Baby weight	Vaginal or Cesarean	Complications?	Term or Pre-Term?

CURRENT MEDICATIONS

Name	Dose	How Often

ALLERGIES

Do you have any medication or environmental allergies?

ALLERGY	TYPE *(eg. Hives, rash, throat swelling, etc)*

MEDICAL HISTORY

- Asthma
- Anemia
- Cancer: _____
- Cardiac disease
- Diabetes
- Hypertension/ High blood pressure
- High cholesterol
- Irritable bowel syndrome
- Lupus
- Thyroid disease
- Thrombotic/Clotting disorder
- H/o DVT/PE
- Stroke
- Osteoarthritis
- Gastrointestinal/ Gallstones
- Kidney stones
- Seizure Disorder
- Headaches
- Anxiety/Depression
- Anesthesia Complications
- Bipolar
- Other:_____

SURGICAL HISTORY

Procedure	Year

FAMILY HISTORY

Has anyone in your immediate family had any of the following?
Mother (M), Father (F), Siblings (S), Grandparent (G) and which side?

Bleeding disorder Yes/No? Who? _____
Blood clots Yes/No? Who? _____
Breast cancer Yes/No? Who? _____
Ovarian cancer Yes/No? Who? _____
Uterine cancer Yes/No? Who? _____
Other Cancer Yes/No? Who? _____
High Blood pressure Yes/No? Who? _____

Diabetes Yes/No? Who? _____
Heart disease Yes/No? Who? _____
High cholesterol Yes/No? Who? _____
Multiple pregnancy Yes/No? Who? _____
Mental Health disorder Yes/No? Who? _____
Thyroid disease Yes/No? Who? _____
Other _____

Mother:
- Living
- Deceased (Cause) _____

Father:
- Living
- Deceased (Cause) _____

SOCIAL HISTORY

Occupation:_____ Marital Status:_____

Do you smoke: (Circle one): **History of No Yes**, How many packs a day? _____
Do you drink Alcohol: (Circle one): **History of No Yes**, How many drinks per week? _____
Do/have you used drugs: (Circle one): **History of No Yes**, Which Drug and last use?_____
Exercise? (Circle One): No Yes, How often and what type? _____

REVIEW OF SYSTEMS

Are you currently experiencing any of the following symptoms?

○ Fatigue	○ Wheezing	○ Breast lump/mass
○ Weight loss	○ Cough	○ Skin Rash
○ Weight gain	○ Nausea/Vomiting	○ Fainting
○ Fever	○ Constipation	○ Seizures
○ Vision changes	○ Diarrhea	○ Numbness
○ Headaches	○ Blood in stool	○ Depression
○ Sinusitis	○ Blood in urine	○ Anxiety
○ Trouble hearing	○ Painful Urination	○ Dry skin
○ Nose bleeds	○ Urgency/Frequency w/ urination	○ Abnormal Thirst
○ Shortness of breath	○ Incontinence	○ Hot flashes
○ Chest pain	○ Muscle pain/weakness	○ Easy bruising
○ Edema	○ Breast pain	○ Abnormal bleeding
○ Heart palpitations	○ Nipple discharge	○ Heavy vaginal bleeding
○ Ulcers	○ Shortness of breath	○ Trouble walking
○ Swollen glands	○ Abnormal vaginal discharge	○ Vaginal dryness
○ Vaginal itching	○ None of the above	○ Other:

WHO ELSE DO YOU SEE/HAVE YOU SEEN?

Primary Care Physician: _____ # _____
Cardiologist: _____# _____
OBGYN: _____# _____
Other physician: _____# _____
Other Physician: _____# _____

Important Office/Financial Policies

Please read thoroughly and sign this form

RELEASE OF MEDICAL INFORMATION / ELECTRONIC MEDICAL BENEFITS:

I authorize Omnia Women's Health Center to release and receive, electronic medical records concerning my Power of attorney/Daughter/self to any pharmacy, physician, hospital or agency involved in my care. This would include electronic medical and electronic prescription history between Omnia Women's Health Center and any pharmacy, physician, hospital, or agency involved in my Power of attorney/Daughter/self's care.

ASSIGNMENT OF MEDICAL BENEFITS:
I authorize my insurance carrier to assign all surgical and or medical benefits to Omnia Women's Health Center. I also authorize release of medical information necessary to process all medical insurance claims.

HIPAA POLICY:
I hereby acknowledge that I have access to a copy of Omnia Women's Health Notice of Privacy Practices.

INSURANCE:
Your health insurance policy is a contract between you and your Health Insurance Company or employer. **Please note it is your responsibility to know your plan's specific rules and/or regulations, including but not limited to the need for referrals, pre-certifications, pre-authorizations, provider coverage, and limits on outpatient charges regardless of whether or not our providers participate.**

We request that you present a current insurance card at each visit. We will bill your insurance company directly for medical services rendered. If problems arise regarding coverage issues, we will **attempt** to work with your insurance company to help resolve them prior to making it your responsibility, but a resolution cannot be guaranteed. Please be advised that **you are ultimately financially responsible for payment of medical services rendered beyond your insurance's plan coverage.**

If you do not present a current insurance card, you will be responsible for payment at the time of your visit. You will receive reimbursement from Omnia Women's Health Center if your insurance pays the claim at a later date.

Before your appointment, please **be sure your doctor is in-network and the services are covered under your plan. If your doctor is out-of-network, you will be billed for the cost of care.**

You have a responsibility to provide information to our office so a claim can be properly submitted. If your insurance company has not paid a claim on your behalf within 90 days, **the balance will be transferred to your account**, and you will be responsible for payment. If we receive payment at a later date, you will be reimbursed.

Please contact your plan to clarify your current health insurance policy benefits and learn the details about your benefits, out-of-pocket fees and coverage limits.

If you are coming to us for a well woman exam, this is a preventative visit, so please note, if you have any problems at this visit, included but not limited to pelvic pain, menstrual irregularities, hormonal issues, infertility, etc. your insurance may choose not to pay for these problems when addressed at a preventative visit. If insurance chooses not to pay for any part of the visit, you will be expected to provide payment for what is not covered. Please ensure you are aware of what is covered before your visit.

For obstetrical patients, it is important to note, your insurance may choose not to pay for certain services deemed outside of the normal obstetrical parameters including but not limited to treatment of urinary tract infections or vaginal infections. In the event insurance chooses not to pay, the responsibility for payment will fall to you as the patient.

If we contact your insurance carrier regarding benefits or authorization on your behalf, **we are not responsible for inaccurate information provided to us by your carrier.** The information about your plan that we relay to you is in good faith.

MEDICARE:

Medicare may not cover some of the services that your doctor recommends. You will be informed ahead of time and given an Advanced Beneficiary Notice (ABN) to read and sign. The ABN will help you decide whether you want to receive services, knowing you are responsible for payment. You must read the ABN carefully.

PAYMENT POLICY:
Co-payments are to be collected at the time services are received. We accept cash, check, and Visa cards and credit cards. All medical services provided are directly charged to the patient or responsible party. If our provider is contracted with your insurance carrier, we will accept their negotiated rate for the charge billed. However, you will be responsible for any balance deemed patient responsibility/ non-covered by your insurance and billed accordingly. Payment is expected in full upon receipt of statement or payment arrangement must be made with our billing office.
All patients over the age of 18, or an emancipated minor will be held financially responsible for all charges incurred.

FAILURE TO PAY:
Patients who ignore overdue/collection notices and fail to pay their balance risk negative credit ratings and possible dismissal from the practice. Past Due accounts may hinder your ability to have appointments scheduled. Should your account balance become uncollectible or if you file bankruptcy, we will continue to see you on an emergency basis only for 30 days, giving you time to find a new source of medical care.

SELF PAY PATIENTS:
Self-pay patients should be prepared to pay at the time of each visit. If you have any questions regarding cost please be sure to call our business office to speak with the staff member before the visit so we may discuss your specific options.

BILLING / STATEMENT POLICY:
I agree, that Omnia Women's Health Center will email/portal me my patient responsibility statements, if I have provided them with an email/home address. If I prefer paper statements to be mailed to me rather than emailed, I will notify the front office.

FEES:
Returned checks are subject to a $25 fee and your account will be placed on a "cash-only basis" until the balance is cleared.
Failure to give 24 hours cancellation notice or failure to keep your scheduled appointment will result in a charge of $25. Missed appointments represent a cost to us, to you, and to other patients who could have been seen in the time set aside for you. If you must cancel an appointment, Omnia Women's Health Center requires a minimum of 24 hours' notice.

FMLA/DISABILITY FORMS:
Omnia Women's Health Center has 7-10 business day turnaround time for any FMLA and/or Disability forms. I understand there is a **$25.00** fee for the paperwork to be filled out as this is an extra service provided by the office. I understand Omnia Women's Health Center will only release my medical records and paperwork to the authorized party/parties that I provide.

REFERRAL POLICY:
I understand that it is my responsibility to obtain a referral through my primary care physician's office if required by my insurance company or communicate with Omnia Women's Health Centers' office for their assistance with this. Failure to do so will result in charges being billed directly to myself.

EMAIL POLICY:
While my email is primarily used as communication between Omnia Women's Health Center and I, it will also be used to keep me informed of services offered and the latest information regarding Omnia Women's Health Center that they feel is valuable to patients. To opt out of email communication including our email statements please notify the front desk.

ADDRESS/INFORMATION CHANGE:
It is important that we have your correct address information on file. Please advise us anytime there is any change to your address, telephone or other contact information. We may mail out lab results, pathology and appointment information in addition to billing statements.
I hereby authorize my insurance benefits to be paid directly to Omnia Women's Health Center. I understand that I am responsible for all charges including my added costs incurred due any effort to collect for services rendered. I realize I am responsible to pay for non-covered services and I hereby authorize the release of pertinent medical information to insurance carriers.
THIS WILL CONTINUE UNTIL REVOKED BY ME IN WRITING. I HAVE READ, UNDERSTAND, AND AGREE TO ABIDE BY THE ABOVE RELEASE OF MEDICAL INFORMATION, PAYMENT AND OTHER OFFICE POLICIES. THIS RELEASE WILL CONTINUE UNTIL REVOKED BY ME IN WRITING.

Signature of Responsible Party:_____Date:_____

Privacy Notice Information

PATIENT CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS IN ACCORDANCE TO HIPAA

I, _____, understand that as part of my health care, Omnia Women's Health Center originates and maintains paper and/or electronic records describing my health history, symptoms, examinations, test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer(s) can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures.
I understand that I have the following rights and privileges.

- The right to review the notice prior to signing this consent/disclosure
- The right to request restrictions as to show how my health information may be used or disclosed to carry out treatment, payment or healthcare operations I understand that Omnia Women's Health is not required to agree with the restrictions requested.

I understand that I may revoke the consent in writing, except to the extent that the organization has already taken in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent this organization may refuse to treat me permitted by Section 164.520 of the Code of Federal Regulations.

I understand that as part of this organization's treatment, payment or healthcare operations, it may become necessary to disclose my protected health information to another entity (Insurance Company, referring physician, consulting physician, hospital, etc) and I consent to such disclosure for these permitted uses, including disclosures via fax or email.

In addition, I also give consent to Omnia Women's Health Center to disclose my protected healthcare information to the following person and/or people:

Name: _____Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____
I fully understand and accept the terms of this consent,
Patient/Guardian Signature: _____Date: _____

HIPAA Privacy Notice

Effective date: 3/14/2022

Thank you for being a valued Omnia Women's Health Center patient. We are providing you with this HIPAA Privacy Notice to educate you on what we do with your "Protected Health Information" or "PHI". PHI is patient information we collect from you to use when we submit a claim to your insurance provider. Submitting this information allows us to be reimbursed for the services we provide to you. Under the regulation of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), we are required to provide you with the information in this notice. This HIPAA Privacy Notice only details what we do with your PHI and is a small portion our complete Privacy Policy. As such, if there is a discrepancy between our HIPAA Privacy Notice and our Privacy Policy, please note the terms of the HIPAA Privacy Notice have priority in the event the topic is related to your PHI, but the Privacy Policy holds priority if the subject at hand pertains to non-PHI information collected from you. Omnia Women's Health Center may for various reasons use your PHI. PHI may be used to identify you, verify the services we provided to you, research past or future health conditions. It is mandatory to inform you of our privacy practices and specify our intended use and disclosure of PHI. In the vast majority of instances, we will only use the amount of PHI necessary to accomplish the purpose of the use or disclosure. The categories of use and disclosure have been detailed below for your review:

We may use and disclose your PHI without your authorization for the following reasons:

- For your treatment and payment for that treatment.
- When required by federal, state or local law, judicial or administrative proceedings, or law enforcement. We may disclose PHI of military personnel and veterans in certain situations.
- For health oversight activities. For example, we will provide information to assist the government when it conducts an investigation.
- To avoid harm. In order to avoid a serious threat to the health or safety of a person or the public, we may provide PHI to law enforcement personnel, departments of health or persons able to prevent or lessen such harm.
- For workers compensation purposes. We may provide PHI in order to comply with workers compensation laws.
- To make specific merchandising offers or send pertinent information about our services directly to you.
- To run our company, including by sharing PHI with our third-party service providers in order to help us offer, support, or provide our products and services. If we do share PHI with our service providers, we are required to enter a written "Business Associate

Agreement" with that service provider, requiring that the service provider complies with HIPAA in the same manner that we are required to.

Opportunities to Object. We may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part.

When We Require Written Authorization. In any other situation not described above, we will ask for your written authorization before using or disclosing any of your PHI. If you choose to sign an authorization to disclose your PHI, you can later revoke that authorization in writing to stop any future uses and disclosures (to the extent that we have not taken any action relying on the authorization).

Incidental Uses and Disclosures. Incidental uses and disclosures of information may occur. An incidental use or disclosure is a secondary use or disclosure that cannot reasonably be prevented, is limited in nature, and that occurs as a by-product of an otherwise permitted use or disclosure. However, such incidental uses or disclosure are permitted only to the extent that we have applied reasonable safeguards and do not disclose any more of your PHI than is necessary to accomplish the permitted use or disclosure.

Your Rights: HIPAA gives you certain rights related to your PHI. You may exercise any of these rights at any time by contacting us at privacy@aria-therapy.com:

Requesting Limits on Uses and Disclosure of Your PHI. You have the right to ask that we limit how we use and disclose your PHI. If we accept your request, we will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that we are legally required or allowed to make.

Choices on How We Send Your PHI to You. You have the right to ask that we send information to you to an alternate address or by alternate means (for example, e-mail instead of regular mail). We must agree to your request so long as we can easily provide it in the format you requested.

To Receive and View Copies of Your PHI. In most cases, you have the right to look at or receive copies of your PHI. If we do not have your PHI but we know who does, we will tell you how to reach the entity that does have it. We will respond to you within 30 days after receiving your request, which must be in writing. In certain situations, we may deny your request with an explanation of our reasons for such denial and your rights to have the denial reviewed. Instead of providing the PHI you requested, we may provide you with a summary or explanation of the PHI as long as you agree to that and to the cost in advance.

List of the Disclosures We Have Made. You have the right to get a list of instances in which we have disclosed your PHI. The list will not include uses or disclosures made: (a) for treatment, payment, or health care operations; or (b) directly to you, to your family or pursuant to a valid authorization. We will respond within 60 days of receiving your request. The list provided will include disclosures made in the last six years unless you request a shorter time. The list will include the date of the disclosure, to whom PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. We will provide the list to you at no charge, but if you make more than one request in the same year, we may charge you a reasonable cost base charge for each additional request and advise you in advance of that charge.

Correcting or Updating Your PHI. If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that we correct the existing information or add the missing information. We will respond within 60 days of receiving your request which you must provide in writing along with the reason for your request. We may deny your request in writing if the PHI is (a) correct and complete, (b) not created by us, (c) not allowed to be disclosed, or (d) not part of our records. Our written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you do not file a written statement of disagreement, you have the right to ask that your request and our denial be attached to all future disclosures of your PHI. If we approve your request, we will make the change to your PHI and inform you, or others, if required, about the changes.

A copy of this Privacy Notice. You can request a copy of this privacy notice be provided to you in paper form. We will send you a paper copy promptly.

Complaints Regarding Your PHI

If you have any questions or any complaints about our privacy practices regarding your PHI, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, you may contact us at management@omniawomenshealth.com. You can request a copy of this notice from the email address listed above at any time.

You also may send a written complaint to the Arizona Department of Health Services at 150 N 18th Ave, Phoenix, AZ 85007. We will take no retaliatory action against you if you file a complaint about our privacy practices.

Patient HIPPA Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company)
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Print Patient Name _____ Date _____

Signature _____