The Center for Women
Obstetrics & Gynecology
J. Harley Barrow, Jr., M.D. & Amanda G. Thornton, A.P.N.
628 Hospital Drive, Ste. 2A
Mountain Home, AR 72653
(870) 425-7300 / (870) 425-4431
www.TheCenterForWomen.net

PATIENT INFORMATION

PATIENT INFORMATION

Patient Full Name: _____ Preferred Name: _____

Maiden Name: _____ Other Names: _____

Date of Birth: _____ Sex: Female / Male SSN: _____ Race: _____

Ethnicity: _____ Marital Status: _____ Driver's License: _____

Primary Language Spoken: _____ Religion: _____

ADDRESS INFORMATION

Full Address: _____

City/State/Zip: _____ County: _____

PHONE

Home: _____ Work: _____ Cell: _____

Which do you want as your PRIMARY phone: _____ Fax: _____

Email: _____

Preferred Method of Contact: Home / Work / Cell / Email / USPS Mail / Portal

EMERGENCY CONTACTS

Emergency Contact Name: _____ Phone: _____ Relation: _____

Emergency Contact Name: _____ Phone: _____ Relation: _____

SPOUSE/PARENT INFORMATION

Spouse Name: _____ Date of Birth: _____ SSN: _____

If under AGE 18:

Mother's Name: _____ Date of Birth: _____ SSN: _____

Father's Name: _____ Date of Birth: _____ SSN: _____

Guardian's Name: _____ Date of Birth: _____ SSN: _____

The Center for Women
Obstetrics & Gynecology

OTHER INFORMATION

Employer Name: _____ Full Time / Part Time

Occupation: _____ Work Phone: _____ Hire Date: _____

Preferred Pharmacy: _____ City/State: _____

INSURANCE INFORMATION

Primary Insurance: _____

Primary Ins Address: _____

Primary Ins ID#: _____ Primary Ins Group #: _____

Primary Ins Effective Date: _____ Primary Ins Phone #: _____

Primary Insured Name: _____ Primary Insured Date of Birth: _____

Secondary Insurance: _____

Secondary Ins Address: _____

Secondary Ins ID#: _____ Secondary Ins Group #: _____

Secondary Ins Effective Date: _____ Secondary Ins Phone #: _____

Secondary Insured Name: _____ Secondary Insured Date of Birth: _____

_____ _____

Patient's Signature **Date Signed**

Please choose who your pediatrician will be?

Dr. George Lawrence ____

Dr. Gregory Elders ____

Dr. Lonnie Robinson ____

Dr. Michael Hagaman ____

Dr. Ronald Bruton ____

Dr. Michael Adkins ____

Other: _____ ____

Undecided *(but will inform CFW once decision made)* ____

_____ _____

Signature *Date*

Lab Consent/Insurance Release

I consent to the collection and testing of my specimen(s).

For the urine sample, I certify that the specimen identified on this form is my own, and that the specimen is fresh and free from any adulteration or contamination. I certify that the information provided regarding my medications is accurate.

I authorize and give full permission to The Center for Women to perform screening test(s) that are consistent with the current standard of obstetrical care. The following tests may be include, but are not limited to:

Urine Specimen	***Pap Smear***
OB Panel	***Urine Culture/Colony Count***
HIV I & II	***Urine Toxicology***
Gonorrhea	***Chlamydia***
Glucose	***Blood Count***
Culture for Group Beta Strep	

I understand my signature requests that payment of authorized insurance or Medicare benefits be made on my behalf to either The Center for Women, Quest Diagnostics or AvuTox for the testing services furnished to me by the physician. I acknowledge that Quest Diagnostics or AvuTox may be an out of network facility with my insurance provider. Insurance will be filed but may not cover all ordered test(s), therefore I understand I am still financially responsible for all charges, whether or not paid by my insurance. I understand that I am financially responsible for all charges, whether or not paid by said insurance. I am also aware that in some circumstances my insurance provider will send the payment directly to me for services provided. Under law, I agree to endorse the insurance check and forward it to the appropriate billing provider (Either The Center For Women, Quest Diagnostics or AvuTox), within 30 days of receipt of said payment. Failure to do so could result in my account being forwarded to a collections agency and reported to the Credit Bureau.

I authorize Quest Diagnostics and AvuTox to release the results of any ordered test(s) to the ordering facility.

I authorize any holder of medical information about me to release to the insurance company or to CMS (Centers for Medicare and Medicaid Services), and its agents any information needed to determine these benefits or the benefits payable to related services. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

I understand that all test results follow strict HIPAA guidelines to protect and maintain my privacy.

The request for this consent has been explained to me. If I should need further explanation or clarification, it will be provided.

_____	_____	_____
Patient Name Printed	***Patient Signature***	***Date***

_____	_____
CFW Representative	***Date***

PATIENT / INSURANCE/ PHARMACEUTICAL / FINANCIAL AGREEMENT

I, the undersigned give permission for The Center for Women clinicians and staff to give me medical treatment. I understand I have the right to refuse any procedure or treatment. I understand I have the right to discuss all medical treatments with my provider within The Center for Women.

I allow the Center for Women to file for insurance benefits to pay for the care I receive if such insurance is in effect.

I authorize J. Harley Barrow, Jr., M.D. or Amanda G. Thornton, A.P.N. to release to my insurance company any medical records or information required by them. I understand my medical insurance may not cover the fee(s) for professional services rendered to me and I am responsible for these fees.

I authorize payment of medical benefits due me to be paid directly to any provider with The Center for Women listed above. A photocopy of this agreement shall be valid as the original. I understand **PAYMENT IS DUE AT THE TIME OF SERVICE**. I may ask for an estimate of fees prior to services being rendered and further understand they may not include any additional or future services ordered for my medical care. Financial arrangements may be made with a counselor for surgical and obstetrical services. Accounts not paid or maintained as in any payment agreements set, are eligible for collection measures.

I authorize The Center for Women permission to access my current and past medications from pharmacy benefit managers or community pharmacies. This can highlight potential medication issues and improve safety and quality of my medical care.

I understand The Center for Women is a participant of SHARE (State Health Alliance for Records Exchange) Arkansas' state-wide health information exchange (HIE) to enhance the care of patients. SHARE allows participating doctors and hospitals to share and retrieve health information in a secure, electronic manner. HIE provides the capability to electronically move clinical information between disparate health care information systems to facilitate access to and retrieval of clinical data, thereby helping to provide safer, timely, efficient, effective, equitable patient-centered care. Any patient can OPT-OUT of this sharing of their records by initialing the next line. By doing this, your records will not be submitted for sharing to other providers that may need to treat you in an emergent situation.

_____ I want to OPT-OUT of having my records entered into the SHARE AR HIE.

I agree that the facility, The Center for Women, or any other collection or servicing agency or agencies retained by the facility (together referred to hereafter as "collectors") to collect any money that I owe to the facility may contact me by telephone or text message at any number given by me or otherwise associated with my account, including but not limited to, cellular/wireless telephone numbers which may result in my incurring fees for the call or text message. I understand, acknowledge and agree that the collectors may contact me by automatic dialing devices and through pre-recorded messages, artificial voice messages or voice mail messages. I further agree that the collectors may contact me using e-mail or any e-mail address I provide to the facility or is otherwise associated with my account.

_____

Printed Patient Name

_____ _____

Patient or Guardian Date Signed

CONSENT FOR ULTRASOUND

TO THE PATIENT: You have the right, as a patient to be informed about the recommended diagnostic procedure to be performed. Your insurance may only cover a limited number of ultrasounds during a certain time span, especially during pregnancy. It is the patient responsibility to know what the insurance coverage is.

We at the Center for Women believe the ultrasound being performed today is medically necessary for the continued care of your health but your insurance may have stipulations or limits. If your insurance denies coverage for the ultrasound being performed today, you will be financially responsible for it.

Marked below is the type of ultrasound that we will be performing along with the cost of the ultrasound. Please review to ensure you want to continue with this diagnostic test.

Obstetrical:

_____	76801 Ultrasound, first trimester (<14 weeks 0 days), transabdominal approach, single or first gestation.	$194.00
_____	76805 Ultrasound, after first trimester (> or = 14 weeks 0 days), transabdominal approach, single or first gestation	$218.00
_____	76810 Ultrasound, each additional gestation – for twins, triplets, etc. (price for each fetus)	$154.00
_____	76815 Ultrasound, limited, (fetal heart beat, placental location, fetal position and/or amniotic fluid volume) 1 or more fetus	$132.00
_____	76816 Ultrasound, follow-up (re-eval fetal size by parameters and fluid volume, fetal organ system(s) suspected abnormal or confirmed on previous scan, transabdominal approach (price for each fetus)	$178.00
_____	76817 Ultrasound, pregnant uterus, transvaginal	$152.00
_____	76820 Doppler velocimetry, fetal; umbilical artery	$ 77.00
_____	76826 Echocardiography, fetal, cardiovascular system, follow-up or repeat study	$244.00
_____	76828 Doppler echocardiography, fetal, follow-up or repeat study	$ 88.00

Non-Obstetrical:

_____	58340 Catheterization & introduction of saline/contrast material for Saline Infusion SIS or HSG	$184.00
_____	76830 Ultrasound, transvaginal	$183.00
_____	76831 Hysterosonography, Supervision and Interpretation (SIS)	$179.00
_____	74740 Hysterosalpingography, Radiological Supervision and Interpretation (HSG)	$113.00
_____	76856 Ultrasound, pelvic, complete	$166.00
_____	76857 Ultrasound, pelvic, limited or follow-up	$ 76.00

Guidance Procedures:

_____	76942 Ultrasound guidance for needle placement (biopsy, aspiration, injection, localization device	$100.00
_____	76946 Ultrasound guidance for amniocentesis	$ 55.00

I have been given an opportunity to ask questions, and have been explained possible alternative forms of diagnostic treatment and or no testing at all. I certify this form has been fully explained to me, that I (we) have read it or have had it read to me (us), that the blank spaces have been filled in, and that I (we) understand its contents. I understand if my insurance does not cover this procedure, I will be responsible for the total charges. I authorize The Center for Women keep my ultrasound on file and can be used for training purposes with the staff in the future provided my identity is not revealed by the pictures or by descriptive text accompanying them.

☐ I DO wish to continue with the ultrasound marked above for today.

☐ I DO NOT wish to continue with the ultrasound marked above for today.

_____ _____ _____ _____

Signature of Patient | Patient name printed | Date Signed | CFW Witness Initials

_____ _____

Signature of Interpreter, legal representative if minor or unable to sign if applicable | Date Signed

PATIENT ACKNOWLEDGEMENT FORM

Patient Acknowledgment of Understanding of The Center for Women's Notice of Privacy Practices.

- **Patient's name: _____ Date of birth: _____**
-
- **SSN: _____ Previous name: _____**

I understand that the patient's health information is private and confidential. I understand the providers at The Center for Women work very hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health information.

I understand that The Center for Women may use and disclose the patient's personal health information to help provide health care to the patient, to handle billing and payment, and to take care of other health care operations. [*In general, there will be no other uses and disclosures of this information unless I permit it. I understand that sometimes the law may require the release of this information without my permission. These situations are very unusual. One example would be if a patient threatened to hurt someone.]

The Center for Women has a detailed document called the "Notice of Privacy Practices". It contains more information about the policies and practices protecting the patient's privacy and is attached to this Acknowledgment. I understand that I have the right to read the "Notice" before signing this Acknowledgment.

The Center for Women may update this Acknowledgment and "Notice of Privacy Practices". If I ask, The Center for Women will provide me with the most current "Notice of Privacy Practices".

Within this Notice of Privacy Practices is contained a complete description of my privacy/confidentiality rights. These rights include, but aren't limited to, access to my medical records; restrictions on certain uses; receiving an accounting of disclosures as required by law; and requesting communication by specified methods of communications or alternative location.

The Center for Women has established procedures that help them meet their obligations to patients. These procedures may include other signature requirements, written acknowledgments, and authorizations; reasonable time frames for requesting information; charges for copies and non-routine information needs; etc. I will assist The Center for Women by following these procedures if I choose to exercise any of my rights described in the "Notice of Privacy Practices".

My signature below indicates that I have been given the chance to review a current copy of The Center for Women's "Notice of Privacy Practices".

- _____ _____

Patient or legally authorized individual signature Date

_____

Relationship to patient if signed by anyone other than the patient (parent, legal guardian, personal representative, etc.)

Name(s) of individuals we may release relevant information to regarding your care and expiration date of access, leave blank if you prefer a never ending date:

Named Individual:	**Expiration Date:**
_____	_____
_____	_____
_____	_____
_____	_____

I acknowledge that I have read and fully understand the **Patient Portal User Agreement and Terms of Use** form. I have been given the risks and benefits of the Patient Portal and understand the risks associated with online communications between The Center for Women and patient, and consent to the conditions outlined herein. In addition, I agree to adhere to the policies set forth herein, as well as any other instructions or guidelines that The Center for Women may impose for using the Portal. I have been proactive about asking questions related to this agreement. All of my questions have been answered with clarity. By signing below, I hereby give my informed consent to participate in The Center for Women Patient Portal, and I hereby agree to and accept all of the provisions contained above.

Patient Name {printed}: _____

Patient Signature: _____

Date: _____

Personal Representative Signature: _____

Personal Representative Relationship: _____

Email Address {printed}:

_____@_____._____

You must ensure that this personal email address is maintained and active. If you change your email address you must notify the Practice. In the event that your password has been stolen or jeopardized, it is your responsibility to change your password or notify us if you need assistance with changing your password.

For more information about this Agreement or about the Portal generally, please refer to your **Patient Portal User Agreement and Terms of Use** that is given to you with this acknowledgement or contact The Center for Women at (870) 425-7300.

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Epidural Waiver

PHYSICIAN NOTICE:

Your Insurance (_____) will not cover services that it determines are not medically necessary or that it classifies as either experimental or investigation in nature. If your above mentioned insurance determines that a particular service, although it would otherwise be covered, is not medically necessary or is experimental or investigational under said insurance plan, then said insurance will deny payment for that service. *We believe that, in your case, your insurance is likely to deny payment for Epidural and/or Spinal Anesthesia for the following reasons: that it is inclusive with another procedure being performed, such as the delivery.* The charge for an Epidural through this office is **$278.00.**

MEMBER AGREEMENT:

I have been notified by my physician/physician staff that they believe that, in my case, my insurance (_____) is likely to deny payment for the services identified above, for the reasons stated. If my insurance denies payment for lack of medical necessity or on grounds of the experimental or investigation nature of the services, or if it's determined inclusive to other services such as the delivery, I agree that I will not look to my insurance to cover these services and that I shall be personally and fully responsible for payment for all such services including any follow-up services that may be required to complete the treatment or to repair any damage or address any complications of treatment.

_____ _____

Patient/Financial Administrator/Member's Signature Date

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NAME:_____ **DATE:**____/____/____ **BIRTHDATE:**____/____/____

REFERRED BY:_____

REASON FOR VISIT: ☐ **ROUTINE OB CARE** ☐ **PROBLEM** **DESCRIBE PROBLEM:** _____

CHECK IF YOU HAD ANY OF THESE MEDICAL PROBLEMS IN THE PAST:

MAJOR ILLNESSES	YES	NO		YES	NO
Anemia			Hepatitis / Jaundice		
Anxiety			Herpes / HSV		
Arthritis / Joint pain			High Blood Pressure		
Asthma			High Cholesterol		
Blood transfusions			HIV / AIDS		
Bowel Trouble			HPV / Human Papilloma Virus		
Breast Cancer			Kidney Infections / Urinary Tract Infections		
Cancer			Kidney Stones		
Chicken Pox			Mood Disorders		
Chlamydia			Pneumonia		
Chronic Lung Disease			Rheumatic Fever		
Depression			Sexually Transmitted Diseases		
Diabetes			Stroke		
Eating Disorder			Syphilis		
Fracture			Tuberculosis - TB		
Glaucoma			Thyroid Disease		
Gonorrhea / GC			Ulcers		
Heart Murmur			OTHER:		
Heart Trouble			Injury		

WHEN WAS YOUR LAST TEST OR IMMUNIZATION?			
	DATE		DATE
Bone Density		Mammogram	
Colonoscopy / Sigmoidoscopy		TB Skin Test	
Flu Shot		Last Normal PAP Smear	
Pneumonia		Last Abnormal PAP Smear	
Tetanus			

PLEASE LIST ANY OPERATIONS OR HOSPITALIZATIONS YOU HAVE HAD:			
SURGERY / HOSPITALIZATION / REASON	DATE	SURGERY / HOSPITALIZATION / REASON	DATE

PLEASE LIST MEDICATIONS THAT YOU ARE CURRENTLY TAKING:					
DRUG NAME	DOSAGE	PHYSICIAN	DRUG NAME	DOSAGE	PHYSICIAN
ALLERGIES TO MEDICATIONS / SUBSTANCES (LATEX GLOVES, ETC.?)	List:				

Patient Name: _____ Patient DOB: _____

Patient Name: _____ Patient DOB: _____

CIRCLE AND CHECK IF YOUR BLOOD RELATIVES HAVE HAD:

MAJOR ILLNESSES	YES	NO	WHAT BLOOD RELATIVE? Mother's / Father's
Anemia			
Arthritis / Joint pain			
Asthma			
Bowel Trouble / Ulcers			
Breast Cancer			
Cancer			
Chronic Lung Disease			
Depression / Anxiety / Mood Disorders			
Diabetes			
Glaucoma			
Heart Trouble / Murmur			
Hepatitis / Jaundice			
High Blood Pressure			
High Cholesterol			
Kidney Infections / Stones			
Stroke			
Thyroid Disease			
Tuberculosis - TB			
OTHER:			

NAME:_____ **BIRTHDATE:**_____/_____/_____

YOUR GYN HISTORY

Are you using any birth control? ☐ Yes ☐ No	
❑ Condoms	❑ NuvaRing
❑ Depo-Provera	❑ Birth Control Patch
❑ Diaphragm	❑ None
❑ IUD- Kind	❑ Natural Family Plan/Rhythm
- Date Inserted:	❑ Tubal Ligation
❑ Birth Control Pill	❑ Vasectomy
– Name:	❑ Withdrawal
❑ Contraceptive Foam/Jelly	❑ Other:
What age did you have your first period: _____	
How many days are there from start of your period to start of next period? _____ days	
How long does your period last? _____ days Flow: ☐ Light ☐ Medium ☐ Heavy	
Date of Last Period: _____ Are you sure of the date? ☐ Yes ☐ No	
Was it a normal period? ☐ Yes ☐ No	

YOUR OB HISTORY

	NUMBER		NUMBER
Total # of pregnancies		Full term births	
Premature delivery (less than 37 weeks)		Abortions / Termination	
Miscarriages		Living children	

On the chart below, please fill in answers for each pregnancy including abortions or miscarriages.

No.	Birth Date	Wks Gest	Labor (hrs)	Baby's Weight/Sex		Del Type Vag/CSection	Epid Y / N	Preterm Labor?	Wt Gain	Comments / Complications	Hospital
1					M F						
2					M F						
3					M F						
4					M F						
5					M F						
6					M F						

NAME:_____ **BIRTHDATE:**_____/_____/_____

SOCIAL HISTORY

PLEASE LIST HABITS
Do you Take Calcium? ☐ Yes ☐ No Name and Dosage:
Do you Exercise? ☐ None ☐ Less than 3 times per week ☐ More than 3 times per week
Do you have sex with? ☐ Men ☐ Women ☐ Both
First Intercourse at Age: _____ New sexual partner? ☐ Yes ☐ No
Lifetime sexual partners ☐ Less than 5 ☐ More than 5
Smoking ☐ Yes ☐ No ☐ Previously Packs per day: _____ Number of Years: _____ Stopped _____ Years ago
Alcohol ☐ Yes ☐ No ☐ Previously Drinks per day: _____ Drink per week: _____
Drug User ☐ Yes ☐ No ☐ Previously Kind: Frequency:
History of abuse ☐ Yes ☐ No ☐ Physical ☐ Emotional ☐ Sexual

List all "Natural" or Herbal remedies, over the counter drugs, vitamins or minerals you are taking.	List:

Occupation:
Race ☐ White ☐ African American ☐ Hispanic ☐ Asian ☐ Other _____
Marital Status ☐ Single ☐ Engaged ☐ Married ☐ Divorced ☐ Widowed

NAME:_____ **BIRTH DATE:** ____/____/_____

REVIEW OF SYSTEMS:

Please Check (X) If Any Of The Following Applies To You NOW.

CONSTITUTIONAL	❑	**NOTES**
Weight Loss	❑	
Weight Gain	❑	
Fever	❑	
Fatigue	❑	
Night Sweats	❑	
Hot Flashes	❑	
EYES	❑	
Double vision	❑	
Vision changes	❑	
HENT	❑	
Headaches	❑	
Dizziness	❑	
Sore Throat	❑	
Sinus Pain	❑	
Nose Bleeding	❑	
Thyroid Mass	❑	
Neck Pain	❑	
BREAST	❑	
Lumps	❑	
Tenderness	❑	
Swelling	❑	
Discharge	❑	
Pain in Breast	❑	
Abn Changes in Breast	❑	
CARDIOVASCULAR	❑	
Chest Pain	❑	
Irregular Heart Beats	❑	
Rapid Heart Rate	❑	

GENITOURINARY (CONT)	❑	**NOTES**
Decreased sex drive	❑	
Painful intercourse	❑	
Possible Pregnancy	❑	
Genital Sores	❑	
SKIN	❑	
Rashes	❑	
Itching	❑	
Skin Dryness	❑	
Skin Lesions	❑	
Changes to Lesions or Moles	❑	
Acne	❑	
NEUROLOGICAL	❑	
Muscular Weakness	❑	
Numbness or Tingling	❑	
Difficulty Concentrating	❑	
Memory Difficulties	❑	
Speech Difficulties	❑	
Seizures	❑	
Loss of Balance	❑	
MUSCULOSKELETAL	❑	
Joint Pain or Swelling	❑	
Muscle Pain	❑	
Back Pain	❑	
ENDOCRINE	❑	
Loss of Hair	❑	
Difficulty Tolerating Cold	❑	
Difficulty Tolerating Heat	❑	
PSYCHIATRIC	❑	

Fainting	❑	Anxiety	❑
Swelling of legs	❑	Depression	❑
Varicose veins	❑	Impulsive Behavior	❑
RESPIRATORY	❑	Suicidal Thoughts	❑
Wheezing	❑	Excessive Anger	❑
Cough	❑	Mood Swings	❑
Shortness of breath	❑	Emotional Abuse	❑
Spitting up blood	❑	Physical Abuse	❑
GASTROINTESTINAL	❑	Sexual Abuse	❑
Nausea	❑	**HEMATOLOGIC/**	❑
Vomiting	❑	**LYMPHATIC**	❑
Diarrhea	❑	Bruises, frequent or easily	❑
Constipation	❑	Cuts do not stop bleeding	❑
Abdominal Pain	❑	Enlarged lymph nodes	❑
Bloody / Black Stool	❑	**ALLERGIC/IMMUNOLOGIC**	❑
Hemorrhoids	❑	Frequent illness	❑
Jaundice	❑	Seasonal Allergies	❑
GENITOURNARY	❑	**OTHER**	❑
Urgency of urination	❑	1.	❑
Frequency of urination	❑	2.	❑
Pain with urination	❑	3.	❑
Nighttime urination	❑	_____	❑
Losing urine	❑	_____	❑
Blood in urine	❑		❑

Patient Name: _____ Patient DOB: _____