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**Welcome – your first visit to the Center for Women’s Health is fast approaching. We are all looking forward to meeting you. If you have access to the internet, you might wish to “check out” our website [www.ctrforwomenshealth.com](http://www.ctrforwomenshealth.com).**

**Our goal is to make this visit as smooth and pleasant as possible. Enclosed is a Patient Registration Form that includes a medical history section. If you are a Medicare patient, please review and sign the Medicare waiver at the bottom of the first page. Kindly bring the completed form along with your insurance card and co-pay (if applicable) with you. In addition, we would appreciate it if you would plan to arrive 10 minutes early so that all of your information can be put into our system and a chart created for you.**

**Also enclosed is a questionnaire concerning bladder and pelvic muscle health as well as a copy of our financial policy guide. Please take a moment to review them.**

**Our office telephone hours for making/changing appointments and requesting prescription renewals are Monday-Thursday from 8:00 a.m. to 4:00 p.m. and Fridays from 8:00 a.m. to 3:00 p.m. Laboratory and ultrasound results may also be obtained during those hours.**

**If it becomes necessary for you to reschedule your appointment, please call the office as soon as possible. This will allow us to give you a new appointment and it will also permit us to schedule another new patient in that time slot.**

**Finally, we are pleased to inform you that we also provide the following additional services: OB ultrasounds, laser hair and spider vein removal and skin care (including microdermabrasion and glycolic peels). Please see any member of our staff for brochures describing these services.**

**Again, thank you for choosing the Center for Women’s Health. If you have any questions or need any additional information, please call me directly at 215/359-0311.**

**Sincerely,**

**Monica J. Pyle, Administrator**

**Enclosures**

[www.ctrforwomenshealth.com](http://www.ctrforwomenshealth.com)

# PATIENT REGISTRATION FORM

NAME		DATE OF BIRTH	AGE
STREET ADDRESS		CITY, STATE, ZIP	E-MAIL:
PHONE # - HOME ( )	WORK # ( )	CELL # ( )	
MARITAL STATUS: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed		OCCUPATION/ EMPLOYER	
SOCIAL SECURITY #	FAMILY PHYSICIAN	REFERRED BY	
SPOUSE'S NAME	DATE OF BIRTH	SOCIAL SECURITY #	PHONE
IF UNDER 18 PARENT / GUARDIAN		SOCIAL SECURITY #	
EMERGENCY CONTACT (OTHER THAN SPOUSE)		PHONE	RELATION

## INSURANCE INFORMATION

**PRIMARY PLAN** \_\_\_\_\_

SUBSCRIBER \_\_\_\_\_ ID # \_\_\_\_\_ GROUP # \_\_\_\_\_

SUBSCRIBER'S DOB \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_

RELATIONSHIP TO SUBSCRIBER:  Self  Spouse  Child  Legal Guardian

**SECONDARY PLAN** \_\_\_\_\_

SUBSCRIBER \_\_\_\_\_ ID # \_\_\_\_\_ GROUP # \_\_\_\_\_

SUBSCRIBER'S DOB \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_

RELATIONSHIP TO SUBSCRIBER:  Self  Spouse  Child  Legal Guardian

## AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN

I hereby authorize direct payment of surgical/medical benefits to Center for Women's Health, P.C. for any services rendered by Neil D. Bluebond, D.O., Amy L. Harvey, M.D., Mark D. Kuhn, M.D., Lester A. Ruppensberger, D.O., Robert L. Berk, M.D., Anne Walker, M.D. or Stephanie Schwartz, M.D. or under his/her supervision. I understand that I am financially responsible for any balance not covered by my insurance.

## AUTHORIZATION TO RELEASE INFORMATION (Insurance Claims Only)

I authorize Center for Women's Health, P.C. to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.

## MEDICARE

I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf.

***A photocopy of these assignments shall be valid as the original.***

PATIENT (Please Print) \_\_\_\_\_ DATE \_\_\_\_\_

PARENT/GUARDIAN (Please Print) \_\_\_\_\_ SIGNATURE \_\_\_\_\_

# MEDICAL INFORMATION:

OTHER PHYSICIANS YOU SEE:

## GYN HISTORY:

First day of last period

Age at first period

Age at menopause

Interval between periods

Numbers of days bleeding

Number of pads/tampons used per day

Sexual Preference:  heterosexual  homosexual  bisexual

Type of contraception used by you or your partner:

Currently

In the Past

Approximate date of last PAP Smear

Mammogram

List any GYN problems in the past, including infections or abnormal PAP smears:

## OB HISTORY:

Total number of pregnancies

Deliveries

Miscarriages

Abortions

DATE	LATE/EARLY/ON-TIME	LABOR (HRS.)	TYPE OF DELIVERY	SEX	WEIGHT	COMPLICATIONS
1.						
2.						
3.						
4.						
5.						
6.						

## MEDICAL HISTORY (Please check all that apply)

YOURS AND YOUR IMMEDIATE FAMILY	YOURSELF	FAMILY (WHO?)	COMMENTS
High Blood Pressure			
Breathing Problems/Asthma			
Breast Disease			
Joundice/Hepatitis			
Gall Bladder Disease			
High Cholesterol			
Bowel Disorders			
Kidney Problems/Stones			
Bladder Infections			
Anemia/Blood Disorders			
Blood Transfusions			
Varicose Veins/Phlebitis			
Diabetes			
Thyroid Disease			
Epilepsy			
Cancer (type?)			
Psychiatric Treatment			
Heart Disease			
Mitral Valve Prolapse			
Migraine			
OTHER (Specify)			

# HOSPITALIZATIONS (including Surgery)

ILLNESS/OPERATIONS	MONTH/YEAR
1.	
2.	
3.	
4.	

## MEDICATIONS (include over-the-counter drugs if taken frequently):

1.	3.	5.
2.	4.	6.

## ALLERGIES TO MEDICINES

TYPE OF DRUG	WHAT HAPPENS? (RASH, ETC.)
1.	
2.	
3.	
4.	

## HABITS (Mark all applicable)

TOBACCO	How long does a pack last?	ALCOHOL	Number of drinks per week?
Marijuana, Amphetamines, Other			
Do you exercise?	(Daily, Weekly, Occasionally)	Type of exercise	
Do you take vitamin supplements?		What?	
Do you have pets?		What type?	
Do you work outside of the home?		Doing what?	
Have you ever been in an emotionally or physically abusive relationship?		Yes No	

## WHY HAVE YOU MADE THIS APPOINTMENT?

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**PRIVACY PRACTICES ACKNOWLEDGEMENT**

I have received a copy of the Center for Women's Health Notice of Privacy Practices.

**SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

I wish to be contacted in the following manner (check the options that apply):

**Home Telephone** \_\_\_\_\_

Check off:  Leave message with detailed information  
 Leave message with call back number

**Work Telephone** \_\_\_\_\_

Check off:  Leave message with detailed information  
 Leave message with call back number

**Cell Telephone** \_\_\_\_\_

Check off:  Leave message with detailed information  
 Leave message with call back number

**Written Communication**

Check off  Mail to home address  
 FAX to this number \_\_\_\_\_

I hereby give permission for the Center for Women's Health to disclose information regarding my treatment to:

**Spouse:** \_\_\_\_\_

**Son/Daughter:** \_\_\_\_\_

**Other Relative - Name:** \_\_\_\_\_

**Physician:** \_\_\_\_\_

**Address:** \_\_\_\_\_

In signing this release, I authorize my medical records to be faxed or mailed upon my request.

**Name** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**GENERAL**

The following information is a guide which outlines our financial policy. If you have any questions regarding our office policy, please feel free to ask our Finance Office. We hope this will be helpful to you in understanding your insurance and healthcare financial responsibility to our practice.

**HEALTH INSURANCE**

Your health insurance is yours and belongs to you or someone in your family. It is your responsibility to know what your insurance does and does not cover. Our practice contracts with your insurance company through a separate agreement to accept their fees for our services, i.e., we are participating providers. We bill your insurance company for services rendered; if the services are covered, we accept payment and you owe only deductibles or co-insurance. If services are not covered, we will balance bill you for the services.

**OFFICE VISITS**

Our office requests payment at the time the service is rendered. Upon payment you will be given a receipt if requested. If you intend to submit this receipt to your insurance company, this receipt can be attached to your insurance form for reimbursement to you. As above, if we are a participating provider with your plan we will submit the claim to your carrier.

**CO-PAYS**

If co-pays are part of your agreement with your insurance company, they are your responsibility. If two different services are provided you may owe 2 co-pays! They are due at the time of service. If you do not have your co-pay you cannot receive the service. We accept cash, checks, Visa and MasterCard.

**VISIT**

When scheduling your appointment be sure to ask if we are participating with your insurance company. We will do our best to provide accurate information; there are so many plans, sometimes it is difficult to know for sure. You, however, have a list provided by your plan. We cannot guarantee we participate in all plans within one company; e.g., Aetna has about 25 different plans. If we do not participate in your insurance, or if we know that a service is not covered, payment is due at the time service is rendered. If you are not sure you may wish to call your carrier to verify participation. Any balances due must be paid prior to the scheduled visit.

**MANAGED CARE PLANS**

If your company requires a referral for an office visit, that referral must be presented to the front desk before you can be seen by the practitioner; or, it must be electronically in our system from your primary. Failure to provide us with such referral at the time of your visit will result in a cancellation of your appointment. You may need a referral for certain studies we may order; there are some that we can provide, but many must be obtained from your primary. We will do everything we can to help the process.

**MEDICARE**

Medicare will cover one routine pap, pelvic and breast exam every two years (24 months). If the visit is a problem visit then other financial responsibilities such as deductibles and balance billing may be incurred. If your visit is denied by Medicare then you will be billed for the unpaid amount; you will also be billed for any unpaid annual deductible owed and any amounts not reimbursed by your secondary insurance.

**IT IS YOUR RESPONSIBILITY TO KNOW AND UNDERSTAND YOUR INSURANCE COVERAGE.**

**CHECK POLICY**

We accept personal checks for payment. However, we cannot accept postdated checks. A fee of \$20 will be added to your balance for any checks returned for insufficient funds.

**PAYMENT PLAN**

We will work out a payment plan should your balance pose a financial burden to you. However, all outstanding amounts must be settled before additional services are rendered. You may be asked to provide proof of financial burden when requesting a payment plan. We do participate in Care Credit financing and may offer this for selected procedures.

**DELINQUENT ACCOUNTS**

If your account becomes past due and there is not a valid reason for your payment delay, appropriate action will be taken to recover the amount due within 90 days of the initial billing. If there are legitimate problems, please discuss them with our Finance Office so that we can help you find a solution.

**MISSED APPOINTMENTS**

Your time is valuable, and so is ours. If you cannot keep your scheduled appointment, we would appreciate timely notice from you. If you miss an appointment (without calling) we reserve the right to charge a fee for that missed appointment. We have a cancellation line on our phone menu.

**ADDITIONAL HELP**

**Our staff is here to help you. If you have any questions regarding insurance filing, fees or statements, please call our Finance Office at 215-359-0307 (-08,-09) or #4 on menu.**

*Thank you for your confidence in our practice, and your understanding in these complex health care issues.*

