

Jeffrey T. Gibson, MD • Vivian Vega, MD  
Byron S. Hapner, DO • Anna Jang-Hanson, MD  
Leisa D. O'Flynn, DO • Lynsey M. Beams, DO  
Karen Norton, MSN, CRNP

# Premier Women's Health

*of South Jersey*

A Division of Regional Women's Health, LLC

Your Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Please list all medications that you take, as well as quantity and frequency:

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Your name:	Date of birth:
Today's date:	
Who is your primary care doctor?:	

*Please help me by updating your health history since your last visit.  
Thanks.  
Byron Hapner, DO*

Since your last visit, have you:

--discovered that you are allergic to anything?  No  Yes What? \_\_\_\_\_

--had any changes in your health, been hospitalized, or had any surgery?  No  Yes  
*Please describe any changes, hospitalizations, or surgery:*

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--had any changes or additions to your medications?  No  Yes  
*Please describe any changes or additions to your medications:*

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--been pregnant?  No  Yes

Do you have any particular health concerns or questions?

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Do you wish to be tested for any sexually transmitted diseases?  No  Yes

Your signature: \_\_\_\_\_



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Echelon One, Suite 300  
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Premier Women's Health of South Jersey  
an Axia Women's Health Care Center  
**HIPAA & REGISTRATION UPDATE FORM**

(Please Print)

Date: / /		Primary Care Phys. (PCP):		PCP Phone No.:	
<b>PATIENT INFORMATION</b>					
Patient's Last Name:		First:	Middle:	Gender:	Marital Status (circle one):
				F M	Single / Mar / Div / Sep / Widow
Birth Date:	Age:	Social Security No.:	Home Phone No.:	Cell Phone No.:	
/ /			( )	( )	
Street Address:			City:	State:	Zip Code:
I authorize messages with medical information to be left on voicemail/answering machine at (check all that apply) <input type="checkbox"/> Home <input type="checkbox"/> Cell above. I authorize: <input type="checkbox"/> Brief message details to be left <input type="checkbox"/> Extended message details to be left <input type="checkbox"/> Restrictions:					
<b>PHARMACY INFORMATION</b>					
Local Pharmacy:		Address:		City:	State:
Mail-Order Pharmacy:		Address:		City:	State:
<b>INSURANCE INFORMATION</b>					
Please give your insurance card(s) to the receptionist.					
Name of Primary Insurance Company:		Subscriber's Name:	Subscriber's SSN:	Subscriber's Date of Birth:	
				/ /	
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Partner <input type="checkbox"/> Other – please explain:					
Name of Primary Insurance Company:		Subscriber's Name:	Subscriber's SSN:	Subscriber's Date of Birth:	
				/ /	
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Partner <input type="checkbox"/> Other – please explain:					
<b>IN CASE OF EMERGENCY</b>					
Name of contact:		Relationship to patient:	Home Phone No.:	Cell Phone No.:	
			( )	( )	
<b>RELEASE OF MEDICAL AND BILLING INFORMATION</b>					
I authorize the following individual(s) to receive information pertaining to any medical history, treatment received and billing matters:					
Name:		Relationship to patient:	Birth Date:	Contact Phone: <input type="checkbox"/> Home <input type="checkbox"/> Cell	
			/ /	( )	
			/ /	( )	
<b>PATIENT PORTAL COMMUNICATION</b>					
We continue to offer secure electronic communications between you and our office via our Patient Portal. Secure messages and information can only be read by someone who knows the right password to log in to the Portal site. The communications are automatically encrypted and for those who want to participate, this secure communication can be a valuable tool to provide administrative and clinical information provided that we maintain your most up-to-date information. <b>Do you wish to either continue to participate or sign up to participate?</b>					
<input type="checkbox"/> Yes, I want to participate, my email is _____ <input type="checkbox"/> No, I do not want to participate at this time.					
<b>MEDICAL CHAPERONE</b>					
I request a female chaperone to be present during my examination. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other (family member, partner, etc. will be present)					
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize my provider or insurance company to release any information required to process my claims.					
Patient Signature				Date	

Patient's Name: \_\_\_\_\_

DOB: \_\_\_\_\_

## Authorization for Treatment & Payment of Medical Benefits Patient Financial Responsibility Form

Thank you for choosing our practice, an Axia Women's Health Care Center, as your healthcare provider. We appreciate the confidence you have shown by your choice and are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our authorization for treatment, payment, and patient financial policies. If you would like to receive a more detailed explanation of our financial policies, please request a copy.

### *Authorization for Treatment & Payment of Medical Benefits*

I give permission to the practice, an Axia Women's Health Care Center, to provide medical services for diagnosis and treatment. I authorize the release of medical information necessary to process any claims for services rendered and for payment from my insurance company to be made directly to the practice, an Axia Women's Health Care Center.

### *Use of Photography*

I agree that any photo identification taken at the time of my appointment will be considered a part of my medical record and will be used solely for the purpose of identification.

### *e-Prescription Consent for Medication History*

With your consent, we may request and use your prescription medication history information using our e-prescription feature. This is for only informational purposes so that an up-to-date record of your medication is available for your treatment and safety.

- Yes, I give consent to obtain my medication history using the e-Prescribing feature.
- No, I do not give consent to obtain my medication history using the e-Prescribing feature. I understand that my medication information may not be complete when making treatment decisions.

### *Patient Financial Responsibilities*

- I (or patient's guardian, if a minor) understand that I am ultimately responsible for the payment of my treatment and care.
- You will assist me by billing your contracted insurers. However, I understand that I am required to provide you with the most correct and updated information about my insurance, and I will be responsible for any charges incurred if the information provided is not correct or updated.
- I understand that I am responsible for the payment of copays, coinsurance, deductibles, and all other procedures or treatment not covered by my insurance plan. I understand that payment is due at the time of service, payable by cash, check, and most major credit cards.
- I understand that I may incur, and am responsible for, the payment of additional charges. These charges may include (but are not limited to):
  - ♦ Charge for returned checks.
  - ♦ Charge for the copying and distribution of patient medical records.
  - ♦ Charge for forms completion.
  - ♦ Charge for missed appointments.

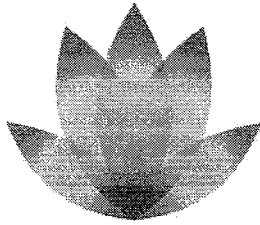
### *Patient Authorizations*

- By my signature below, I hereby authorize the practice, an Axia Women's Health Care Center, to release medical and other information to the necessary insurance companies and third party payers required for payment of rendered health services.
- By my signature below, I hereby authorize assignment of financial benefits directly to the practice, an Axia Women's Health Care Center. I understand that I am financially responsible for charges not covered or denied in full or in part by my insurance plan(s).

**I have read, understand, and agree to the provisions of this Authorization for Treatment & Payment of Medical Benefits and Patient Financial Responsibility Form:**

\_\_\_\_\_  
Signature of Patient or Guardian

\_\_\_\_\_  
Date



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Patient Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Dear Patient:

The State of New Jersey mandates that every physician office document any barrier to care including physical impairments, cultural and linguistic needs in their medical records.

**Please assist us by answering the following questions:**

Do you have any Impairment – Visual, Hearing, Speech, learning, physical or language/cultural barrier?

What language do you speak, read, or write?

Do you have any religious or culture customs that the provider should know about?

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_

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Hofmann Professional Building • 340 W. Front Street, Suite 201 • Elmer, NJ 08318  
100 Lexington Road, Building 100 • Woolwich Township, NJ 08085  
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