NEW PATIENT FORM

FIRST NAME: _____

LAST NAME: _____

DOB: _____

GUADALUPE VALLEY
WOMEN'S HEALTH CARE CENTER

Cell Phone: _____

Email: _____

Preferred Contact Method: ☐ Phone ☐ Email

Mailing Address: _____

Marital status: _____ **Preferred Language**: _____

Race: ☐ White ☐ Black ☐ Asian ☐ American Indian ☐ Native Hawaiian ☐ Other: _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Other: _____

Occupation: _____

Employer: _____ **SSN**: _____

Emergency Contact Name: _____ **Relationship**: _____

Emergency Contact Phone: _____

May we release health information about you to family member(s) or other individual(s):

☐ Yes ☐ No If so, please list: _____

** Please bring your ID and Insurance Card(s) with you to show to receptionist **

** Copays due at the time of service **

** Private pay or Uninsured Patients: payment for services due at the time of service **

** Kindly give 24 hours' notice for rescheduled or cancelled appointments **

** Multiple no show appointments may be subject to patient dismissal from the practice **

Phone (830) 372-0600 contact@gvwhcc.com Fax (830) 372-0602

NEW PATIENT FORM

FIRST NAME: _____

LAST NAME: _____

DOB: _____

GUADALUPE VALLEY
WOMEN'S HEALTH CARE CENTER

COMPREHENSIVE HEALTH HISTORY QUESTIONNAIRE

Menstrual History:

At what age did your periods start: _____ Interval: _____ Duration: _____

Last period?: _____ Flow: ☐ Heavy ☐ Light Painful: ☐ Yes ☐ No

OB History:

Number of pregnancies: _____ Living children: _____

Voluntary termination of pregnancy: _____ Age of youngest child: _____

Miscarriages: _____

GYN History:

Have you ever been told you had:

Chlamydia, Gonorrhea, or Herpes ☐ Yes ☐ No

HPV ☐ Yes ☐ No

Surgical History:

Have you ever had any of the following:

Hysterectomy ☐ Yes ☐ No

C-Section ☐ Yes ☐ No

D&C ☐ Yes ☐ No

Ablation ☐ Yes ☐ No

Tubal ligation ☐ Yes ☐ No

Patient Services:

☐ Well Woman Exam ☐ GYN Problem

☐ Birth Control (Pills, Depo, IUD, Nexplanon) ☐ Surgery (pre-Op, post-Op)

☐ Colpo biopsy, Endometrial biopsy, Vulvar biopsy ☐ Consult (referral from another physician)

Phone (830) 372-0600 contact@gvwhcc.com Fax (830) 372-0602

NEW PATIENT FORM

FIRST NAME: _____

LAST NAME: _____

DOB: _____

GUADALUPE VALLEY
WOMEN'S HEALTH CARE CENTER

MEDICATION LIST

Preferred pharmacy: _____

List your medical allergies: _____

Name of Medication	Dose	Times taken per day
1) _____	_____	_____
2) _____	_____	_____
3) _____	_____	_____
4) _____	_____	_____
5) _____	_____	_____
6) _____	_____	_____
7) _____	_____	_____
8) _____	_____	_____
9) _____	_____	_____
10) _____	_____	_____
11) _____	_____	_____
12) _____	_____	_____
13) _____	_____	_____
14) _____	_____	_____
15) _____	_____	_____

Phone (830) 372-0600 contact@gvwhcc.com Fax (830) 372-0602

NEW PATIENT FORM

FIRST NAME: _____

LAST NAME: _____

DOB: _____

GUADALUPE VALLEY
WOMEN'S HEALTH CARE CENTER

GENERAL CONSENT FOR TREATMENT & FINANCIAL POLICY

1) **Permission for Treatment**: I hereby consent to and authorize the physicians, nurse practitioners, physician assistants, and clinical staff of this practice to provide medical care, evaluation, and treatment as deemed necessary for the patient named in this record.

This may include, but is not limited to:

- Medical history review and physical examination
- Diagnostic testing (laboratory, imaging, cognitive testing, etc.)
- Medication management and prescribing
- Preventive care and health maintenance
- Procedures or treatments performed by qualified clinical personnel

I understand that:

- The practice of medicine is not an exact science, and no guarantees have been made regarding the outcome of care.
- My care may be delivered by a team-based model, including physicians, nurse practitioners (NPs), physician assistants (PAs), and other licensed clinical staff.
- Clinical staff may assist in care delivery under appropriate supervision.

Telehealth Consent (*if applicable*)

I consent to receive medical care via telehealth (video, phone, or electronic communication), when appropriate.

I understand:

- Telehealth has limitations compared to in-person visits
- There may be technical failures beyond the provider's control
- My privacy will be protected using secure systems to the extent possible
- I may request an in-person visit at any time when clinically appropriate

Initials _____

2) **Consent for Communication**: I consent to receive communications from the practice regarding my care, including:

- Appointment reminders

Phone (830) 372-0600 contact@gvwhcc.com Fax (830) 372-0602

- Test results
- Billing and account notifications

These may be delivered via:

- Phone calls
- Text messages (SMS)
- Email

I understand standard messaging/data rates may apply and that privacy risks exist with electronic communication.

Initials _____

3) **Release of Medical Information (HIPAA Acknowledgment)**: I authorize this practice to use and disclose my protected health information (PHI) for purposes of:

- *Treatment* (care coordination, referrals, prescriptions)
- *Payment* (insurance billing, claims processing, collections)
- *Healthcare Operations* (quality improvement, administrative functions)

This may include sharing information with:

- Insurance companies
- Laboratories and imaging centers
- Pharmacies
- Other healthcare providers involved in my care

I understand:

- Only the minimum necessary information will be disclosed when appropriate
- I may request restrictions on certain disclosures (though not all requests can be honored)
- I may revoke this authorization in writing at any time

Initials _____

4) **Assignment of Benefits**: I hereby assign and authorize payment of medical benefits directly to the provider for services rendered.

Phone (830) 372-0600 contact@gvwhcc.com Fax (830) 372-0602

NEW PATIENT FORM

FIRST NAME: _____

LAST NAME: _____

DOB: _____

I understand:

- My insurance policy is a contract between me and my insurance company
- The provider is not responsible for coverage decisions
- I remain financially responsible for all charges not covered by insurance

This includes:

- Deductibles
- Copayments
- Coinsurance
- Non-covered services

I authorize the provider to release necessary medical information to process claims.

Initials _____

5) **Financial Responsibility Agreement**: I agree to be financially responsible for all services provided.

I understand and agree that:

- Payment (including copays) is due at the time of service unless prior arrangements are made
- If my insurance does not pay, I am responsible for the full balance
- Estimated patient responsibility amounts are not guarantees of coverage
- I may receive separate bills from laboratories, imaging centers, or other third parties

Missed Appointment Policy

I understand that missed or late-cancelled appointments may result in a fee.

Collections

If my account becomes delinquent:

- The account may be sent to collections
- I may be responsible for additional fees, including collection costs and legal fees where permitted

Card on File (*Optional but Recommended*)

Phone (830) 372-0600 contact@gvwhcc.com Fax (830) 372-0602

NEW PATIENT FORM

FIRST NAME: _____

LAST NAME: _____

DOB: _____

I authorize the practice to charge my card on file for outstanding balances after insurance processing, unless I make alternative arrangements.

Initials _____

6) **Prescription & Pharmacy Benefits Consent**: Formulary Benefits Data are maintained for health insurance providers by organizations known as Pharmacy Benefit Managers (PBM). PBM's are third-party administrators of prescription drug programs whose primary responsibilities are processing and paying prescription drug claims. They also develop and maintain formularies, which are lists of dispensable drugs covered by a particular drug benefit plan.

I authorize the practice to access my prescription history, insurance drug coverage, and pharmacy benefits electronically through secure health information networks (e.g., Surescripts, RxHub, etc.).

This allows the practice to:

- Review medication history
- Check insurance coverage and copays
- Identify therapeutic alternatives
- Electronically prescribe medications

Initials _____

7) **Credit Care Fee Disclosure**: To offset processing costs, a 3% surcharge may be applied to credit card payments.

- This fee does not exceed the cost of acceptance
- No fee is applied to debit card payments

By signing below, I acknowledge and agree to this policy.

Initials _____

8) **Notice of Privacy Practices (NPP) Acknowledgement**: I acknowledge that the Practice offered me a copy of the Notice of Privacy Practices.

I understand:

- I may request a copy at any time

Phone (830) 372-0600 contact@gvwhcc.com Fax (830) 372-0602

NEW PATIENT FORM

FIRST NAME: _____

LAST NAME: _____

DOB: _____

- The practice maintains policies regarding the use and protection of my health information

Initials _____

9) **Patient Acknowledgement and Signature**: By signing below, I confirm that:

- I have read and understand the above policies
- I have had the opportunity to ask questions
- I agree to the terms outlined

Patient / Responsible Party Signature: _____

Date: _____

Relationship (*if not patient*)**:** _____

Phone (830) 372-0600 contact@gvwhcc.com Fax (830) 372-0602