COASTAL
WOMEN'S
HEALTH

(386) 427-4441

433 North Causeway New Smyrna Beach, FL 32169

GENERAL INFORMATION

We strive to maintain a professional and caring environment to care for you. We work to streamline your visit and provide information as clearly as possible to create a comfortable and long-lasting relationship.

OFFICE HOURS

Monday-Thursday 8:00 am-4:30 pm, (closed 12-1:00 pm for lunch)

Fridays closed

Dr. Metchick or a covering physician is available for any emergencies during non-business hours. Call (386)427-4441. Dr. Metchick does not communicate via any social media for any personal medical questions or concerns.

APPOINTMENTS

We will send an email and text message to confirm your appointment if you have provided us with such information. Email will be from "Patient Fusion". If you do not receive an email or text, please understand that you are still scheduled for your appointment. If unable to confirm, we will not remove you from the schedule but we may over book your time. You are always welcome to call us to confirm the appointment.

INSURANCE CARD/IDENTIFICATION CARD POLICY

Your CURRENT insurance card and valid identification card are required at every appointment.

NO SHOW POLICY

If you are unable to make your appointment you are required to notify the office **24 hours in advance.** If we are not notified, you will incur a fee of $50.00. You may cancel your appointment after hours by leaving a message with the answering service by calling (386) 427-4441. Please understand that we appreciate knowing this ahead of time so we may accommodate another patient.

PRESCRIPTIONS

Please contact your pharmacy when you need a refill, and they will fax us a request to refill, which will expedite the process. Please allow 72 hours to process your request. Refills are not processed during nonbusiness hours.

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CONSENT FOR TREATMENT

I hereby give consent to Heather Metchick, M.D. and/or other Providers in the practice to provide and perform medical care, procedures, order tests, prescribe medications and any other services that are considered necessary or beneficial for my health and well-being.

This consent will remain active until I withdraw my consent in writing.

_____ _____

Print patient name *Date of birth*

_____ _____

Patient/Responsible Party *Date*

CONSENT FOR TREATMENT OF A MINOR

I hereby authorize Dr. Metchick or her staff to examine and/or treat as described above.

_____ _____

Print Minor's Name *Date of birth*

_____ _____

Signature of Parent/Legal Guardian *Date*

_____

Print name of Parent/Legal Guardian

_____

Witness

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CONSENT FOR PAYMENT

I am aware that any outstanding balance, co-payment, co-insurance or deductible incurred is payable by me at the time of service. If unable to pay, we will politely reschedule your appointment.

I am aware that my insurance policy may not cover a Well Woman Exam (WWE) every year. Medicare covers a WWE every 2 years. The WWE may or may not include a pap smear. I am aware that WWE and a "problem visit" are usually considered by insurance companies as two separate visits. Therefore, one or the other may be denied if addressed at the same time, and I will be responsible for the cost of the denied service.

If my insurance company determines that a particular service is not "reasonable and necessary" then the visit may be denied coverage and I will be responsible for the cost of the service.

I am aware of the importance of my scheduled appointment time, and if I am unable to keep my appointment, I will notify the office 24 hours in advance. Otherwise, I understand that I will be charged a $50.00 fee.

Patient Name (print): _____Date of Birth: ___/_____/___

Patient Signature: _____ Date: _____/_____/_____

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Name: ______________________________Age: ____DOB: ____/_____/____

Address: ____

City: ______________________________St: _________Zip: ___________

Home Phone: _____________Cell Phone: _______________Work Phone: ___________

Email: ______________________________SS#: ____________________

Marital Status: S M D W

Emergency contact: ____________________Relation: __________Phone: __________

Employer: _________________________ Occupation: ____________________

Address: ______________________City: ________________St: _____Zip: _____

Please list anyone that you wish for us to discuss your care, finances, etc.:

Name: ______________________Relation: _____________Phone: _____________

>>

MUST BE SIGNED

RELEASE OF INFORMATION, BENEF ASSIGNMENT, PAYMENT AUTHORIZATION, FULL DISCLOSURE STATEMENT AND AGREEMENT TO PAY FOR PROFESSIONAL SERVICES

I hereby authorize Heather Metchick, M.D. to release information necessary to process my insurance/Medicare claim, acquired in the course of my examination or treatment; to allow a photo copy of my signature to be used to process my insurance/Medicare claim for a period of LIFETIME. I claim any insurance benefits due to me for services rendered by Heather Metchick, M.D. and authorize and direct my carrier to issue payment directly to Heather Metchick, M.D. regardless of insurance benefits, if any. I understand that I am fully financially responsible for all fees incurred, and I agree to pay such fees in full. The insurance information furnished represents a full disclosure of the insurance/third party benefits to which I am entitled. I understand that failure to disclose of pre-certification/second opinion requirements for any and all plans to which I subscribe may cause me to incur full liability for professional charges, as a result of nonpayment by a carrier. I authorize Heather Metchick, M.D. and her staff to call my home or other alternate numbers and leave a message on voicemail or in person in reference to any items that assist the practice, such as appointment reminders, insurance items, and any calls pertaining to my clinical care.

Patient Signature: ____________________________________ Date: _____/_____/_____

(Parent or Legal Guardian if minor)

Name of Patient (print): ______________________________DOB____/____/_____

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Patient Name: _____DOB: ___/___/___ Date: ___/___/___

MEDICAL HISTORY

PREVENTATIVE CARE

Last Pap Smear: _____ Last Bone Density Scan: _____

Last Mammogram: _____ Last Colonoscopy: _____

Gardasil Vaccine Completed: _____

Please explain any previous abnormal pap smear or mammogram:

_____

_____

MENSTRUAL HISTORY

Age periods began: _____ Age periods stopped: _____

First day of last period: _____Periods occur every _____ days, and last for _____ days

Are periods normal? If not, please explain:

_____

_____

OBSTETRICAL HISTORY

Number of total pregnancies: _____ Full Term Live births: _____ Preterm Live Births: _____

Miscarriages: ____ Abortions: ____ Living Children: ____

List any pregnancy related medical conditions or complications: _____

CONTRACEPTION

Current method of contraception: _____

List any other methods previously used: _____

List any complications or side effects to any method: _____

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Patient name: _____ DOB: ___/___/___

MEDICAL HISTORY PAGE 2

PAST MEDICAL HISTORY

Anemia	____	High Blood Pressure	____	Lupus	____
Asthma	____	High Cholesterol	____	Stroke/CVA	____
Arthritis	____	Heart Attack	____	Seizure	____
Anxiety	____	Heart Failure	____	DVT/Phlebitis	____
Bowel Disorder	____	Hepatitis A, B or C	____	Stomach Ulcers	____
Colitis/IBS	____	HIV	____	GERD	____
Cancer (type)	____	Liver disease/cirrhosis	____	Thyroid disease	____
Diabetes	____	Emphysema/COPD	____	Any other not listed:	
Depression	____	Kidney Failure	____	_____	

SOCIAL HISTORY

Do you smoke? _____ If so, how many cigarettes per day? ____ E cigarette use? ____
Do you drink alcohol? _____ How many drinks per day or week? _____

Drug use? _____ If so, what type? _____

PAST SURGICAL HISTORY

Please list all surgical procedures and year performed:

_____

_____

FAMILY HISTORY

Please list any significant family medical history. Please list who and what problems:

_____

_____

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Patient name: _____ DOB: ___/___/____

MEDICAL HISTORY PAGE 3

GYNECOLOGY HISTORY

Abnormal pap Y/N Chlamydia Y/N Gonorrhea Y/N Herpes Y/N PMS Y/N

Recurrent yeast or BV Y/N Endometriosis Y/N Pain with intercourse Y/N

Genital Warts Y/N Fibroids Y/N Ovarian Cysts Y/N Chronic Pelvic Pain Y/N

Hot Flashes/Night Sweats Y/N Breast Disease Y/N GYN Cancer Y/N

Please provide any details of any "YES" response:

_____

_____

Please list any other gynecology condition that you have or had that is not listed above:

_____

ALLERGIES AND MEDICATIONS

Please list any medication or environmental allergies and your reaction:

_____

_____

Please list **ALL** medications, including vitamins and supplements. Please include the strength of the dose and frequency of use: (*please attach additional page as needed so as to not exclude anything*)

_____

_____

_____

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Patient name: _____DOB: ___/___/___

REVIEW OF SYSTEMS

Please list any symptom you are experiencing currently:

_____

_____

PRIMARY CARE PHYSICIAN:

_____

PHARMACY NAME AND LOCATION:

_____

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ACKNOWLEDGEMENT OF RECEIPT
Notice of Patient Privacy Practices

I understand that under the Health Insurance Portability and Accountability Act (HIPPA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of the Notice of Privacy Practices. I also understand that this practice has the right to change the Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

_____ ___/___/___

(Patient Name Print) *Date of birth*

_____ ___/___/___

(Patient/Legal Guardian Signature) *Date*

_____

(Legal Guardian Name Print)

Acknowledgement NOT obtained because:

_____ Patient/Legal Guardian declined notice of Patient Privacy Practices

_____ Other (briefly describe) _____

Employee Signature: _____

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEATHER M. METCHICK M.D. MAY USE AND DISCLOSE YOUR HEALTHCARE INFORMATION AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Heather M. Metchick M.D., is required by law to maintain the privacy of your protected health information. This information consists of all records related to your health, including demographic information, either created by Heather M. Metchick M.D. or received by Heather M. Metchick M.D., from other healthcare providers.

We are required to provide you with notice of our legal duties and privacy practices with respect to your protected health information. These legal duties and privacy practices are described in this Notice. Heather M. Metchick M.D., will abide by the terms of this Notice, or the Notice currently in effect at the time of the use or disclosure of your protected health information.

Heather M. Metchick M.D., reserves the right to change the terms of this Notice and to make any new provisions effective for all protected health information that we maintain. Patients will be provided a copy of any revised Notices upon request. An individual may obtain a copy of the current Notice from our office at any time.

Uses and Disclosures of Your Protected Health Information not Requiring Your Consent

Heather M. Metchick M.D. may use and disclose your protected health information, without your written consent or authorization, for certain treatment, payment and healthcare operations. There are certain restrictions on uses and disclosures of treatment records, which include registration and all other records concerning individuals who are receiving, or who at any time have received services for mental illness, developmental disabilities, alcoholism, or drug dependence. There are also restrictions on disclosing HIV test results.

Treatment may include:

- Providing, coordinating, or managing healthcare and related services by one or more healthcare providers:
- Consultations between healthcare providers concerning a patient;
- Referrals to other providers for treatment;

Payment activities may include:

- Activities undertaken by Heather M. Metchick M.D. to obtain reimbursement for services provided to you;
- Determining your eligibility for benefits or health insurance coverage;
- Managing claims and contacting your insurance company regarding payment;
- Collection activities to obtain payment for services provided to you;
- Reviewing healthcare services and discussing with your insurance company the medical necessity of certain services or procedures, coverage under your health plan, appropriateness of care, or justification of charges;
- Obtaining pre-certification and pre-authorization of services to be provided to you.

Healthcare operations may include;

- Contacting healthcare providers and patients with information about treatment alternatives;
- Conducting quality assessment and improvement activities;
- Conducting outcomes evaluation and development of clinical guidelines;
- Protocol development, case management, or care coordination;
- Conducting or arranging for medical review, legal services, and auditing functions.

We may not disclose your protected health information to family members or friends who may be involved with your treatment or care without your written permission. Health information may be released without written permission to a parent, guardian, or legal custodian of a child; the guardian of an incompetent adult; the healthcare agent designated in an incapacitated patient's healthcare power of attorney; or the personal representative or spouse of a deceased patient. There are additional situations when Heather M. Metchick M.D., is permitted or required to use or disclose your protected health information without your consent or authorization. Examples include the following:

As permitted or required by law. In certain circumstances we may be required to report individual health information to legal authorities such as law enforcement officials, court officials, or government agencies. We may have to report abuse, neglect, domestic violence or certain physical injuries. We are required by law to report gunshot wounds or any other wound to law enforcement officials if there is reasonable cause to believe that the wound occurred as a result of a crime. Mental health records may be disclosed to law enforcement authorities for the purpose of reporting an apparent crime on our premises.

For public health activities. We may release healthcare records, with the exception of treatment records, to certain government agencies or public health authority authorized by law, upon receipt of written request from that agency. We are required to report positive HIV test results to the Department of Health. We may also disclose HIV test results to other providers or persons when there has been or will be risk of exposure. We may report the Department of Health the name of any person known to have been significantly exposed to a patient who tests positive for HIV. We are required by law to report suspected child abuse and neglect and suspected abuse of an unborn child, but cannot disclose HIV test results in connection with the reporting or prosecution of alleged abuse or neglect. We may release healthcare records, including treatment records and HIV test results, for the purpose of reporting elder abuse or neglect, provided the subject of the abuse or neglect agrees, or if necessary to prevent serious harm. Records may be released for the reporting of domestic violence if necessary to protect the patient or community from imminent and substantial danger.

For health oversight activities. We may disclose healthcare records, including treatment records, in response to a written request by any federal or state Governmental agency to perform legally authorized functions, such as management audits, financial audits, program monitoring and evaluation, and facility or individual licensure or certification. HIV test results may not be released to federal or state governmental agencies, without written permission, except to the Department of Health for surveillance, investigation, or to control communicable diseases.

Judicial and Administrative Proceedings. Patient healthcare records, including treatment records and HIV test results, may be disclosed pursuant to a lawful court order. A subpoena signed by a judge is sufficient to permit disclosure of all healthcare records.

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For activities related to death. We may disclose patient health care records, except for treatment records, to a coroner or medical examiner for the purpose of completing a medical certificate or investigating a death. HIV test results may be disclosed under certain circumstances.

For research. Under certain circumstances, and only after a special approval process, we may use and disclose your health information to help conduct research

To avoid a serious threat to health or safety. We may report a patient's name and other relevant data to the Department of Transportation if it is believed the patient's vision or physical or mental condition affects the patient's ability to exercise reasonable or ordinary control over a motor vehicle. Healthcare information, including treatment records and HIV test results, may be disclosed where disclosure is necessary to protect the patient or community from imminent and substantial danger.

For workers' compensation. We may disclose your health information to the extent such records are reasonably related to any injury for which workers compensation is claimed.

Heather M Metchick M.D., will not make any other use or disclosure of your protected health information without your written authorization. You may revoke such authorization at any time, except to the extent that Heather M Metchick M.D., has taken action in reliance thereon. Any revocation must be in writing.

Your Rights Regarding Your Protected Health Information

You are permitted to request that restrictions be placed on certain uses or disclosures of your protected health information by Heather M. Metchick M.D., to carry out treatment, payment or healthcare operations. You must request such a restriction in writing. We are not required to agree to your request, but if we do agree, we must adhere to the restriction, except when your protected health information is needed in an emergency treatment situation. In this event, information may be disclosed only to healthcare providers treating you. Also, a restriction would not apply when we are required by law to disclose certain healthcare information.

You have the right to review and/or obtain a copy of your healthcare records, with the exception of psychotherapy notes, or information compiled for use(or in anticipation for use) in a civil, criminal, or administrative action or proceeding. Heather M Metchick M.D., may deny an access under other circumstances, in which case you have the right to have such a denial reviewed. We may charge a reasonable fee for copying your records.

You may request that Heather M. Metchick M.D., send protected health information, including billing information, to you by alternative means or to alternative locations. You may also request that Heather M. Metchick M.D., not send information to a particular address or location or contact you at a specific location, perhaps your place of employment. This request must be submitted in writing. We will accommodate reasonable requests by you.

You have the right to request that Heather M. Metchick M.D., amend portions of your healthcare records, as long as such information is maintained by us. You must submit this request in writing, and under certain circumstances the request may be denied.

Any person or patient may file a complaint with Heather M. Metchick M.D., and/or the Secretary of Health and Human Services if they believe their privacy rights have been violated. To file a complaint with Heather M. Metchick M.D., please contact the Privacy Officer at the following location:

Privacy Officer
Heather M. Metchick M.D.
433 North Causeway
New Smyrna Beach, FL 32169

It is the policy of Heather M Metchick M.D., that no retaliatory action will be made against any individual who submits or conveys a complaint of suspected or actual non-compliance or violation of the privacy standards.

This Notice of Privacy Practices is effective August 7, 2014.