Hawaii Women's Healthcare
Comprehensive Care in Obstetrics and Gynecology

Cheryl Lynn T. Rudy, M.D.
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Andrea Wieland, APRN

Welcome to Hawaii Women's Healthcare

Hawaii Women's Healthcare strives to provide you with the best medical care possible. We are dedicated to caring for women in all phases of their lives. For many women, having a female physician can be comforting when dealing with sensitive women's health issues. We understand your concerns from a woman's point of view. We are strong advocates on many women's health care issues and are dedicated to improving the quality of medical care for women in our community.

- **Payment** – Payment is requested on the day of service. This will enable us to minimize the cost of billing and postage thus keeping our medical fees to a minimum. We accept cash, checks and credit cards. There is a $10.00 billing fee if payment is not received on the day of service. Delinquent payment after 90 days will be referred to our collection agency. There is a $25.00 collection fee if your account is referred to our collection agency. If you are having financial difficulties, please contact our office.
- **Appointments** – We have set aside time for your visit which may prevent others from being seen that day. **You may be assessed a $25.00 no-show fee if you fail to keep your appointment or cancel within 24 hours of your scheduled time.** Please arrive for your appointment no later than 15 minutes before your appointment time for optimum patient flow. **Due to the nature of our specialty, the physician may be called out of the office for an emergency. At this time, you will have the option to reschedule your appointment or returning for a later appointment.**

Authorization to release information and insurance payments

I request payment of authorized Medicare and/or other insurance company benefits be made to me or on my behalf to **Andrea Wieland, APRN** for any services furnished to me by that physician. I authorize any holder of medical information about me to release it to the above insurance carriers or to the Health Care Financing Administration and its agents if required, any information needed to determine these benefits or the benefits payable for related services which may include information on sexually transmitted diseases and HIV. I understand that I am responsible for any amount not covered by my insurance.

_____ _____

Signature of Patient or Legal Guardian Date

_____

Print Name of Patient or Legal Guardian

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Patient Information

Patient Name (Last, First, Middle)			Date of Birth	Social Security Number
Patient Address			City, State, Zip Code	
Primary Phone Number	Cell Phone Number		E-mail Address	
Marital Status	Are you a student? Full or Part Time?	How were you referred to us?		
Employer	Occupation		Work Number	
Person responsible for the bill	Relationship to you		Phone Number	
Billing Address			City, State, Zip Code	
Emergency Contact	Relationship to you	Phone Number	Address	
Patient's Signature			Date	

Insurance Information

Primary Insurance Company	Policy Number		Coverage Code	Group Number
Subscriber's Name	Subscriber's Date of Birth	Subscriber's Social Security Number		Effective Date
Subscriber's Employer	Subscriber's Occupation		Subscriber's Work Number	
Insurance Mailing Address				
Secondary Insurance Company	Policy Number		Coverage Code	Group Number
Subscriber's Name	Subscriber's Date of Birth	Subscriber's Social Security Number		Effective Date
Subscriber's Employer	Subscriber's Occupation		Subscriber's Work Number	
Insurance Mailing Address				

The undersigned hereby authorize the release of any information relating to all claims for benefits submitted on behalf of myself and or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered, or for services to be rendered without obtaining my signature on each and every claim to be submitted for myself and or dependents. I will be bound by this signature as though the undersigned had personally signed the particular claim.

I, _____, hereby authorize _____
(Patient's Name) (Name of insurance company)

to pay and hereby assign directly to **Andrea Wieland, APRN** all benefits, if any, otherwise payable to me for services.
I understand I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid to

Andrea Wieland, APRN will be credited to my account, in accordance with the above said assignment.

Subscriber's signature_____ Date _____

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Medical History Data Base

Please complete all items. If is not applicable, please write N/A.

Date: _____

Name: _____ Age: _____ Date of Birth: _____

Ethnic/Racial Background: _____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Occupation: _____ Referred by: _____

A. PERSONAL MEDICAL HISTORY:

1. List medications you are currently taking: _____
2. List any allergic/reaction you've had to any drug, medication or other substance _____
3. Have you ever had or needed treatment for: Clinician's Notes:

Severe or Frequent Headaches	☐ Yes	☐ No	Date _____
High Blood Pressure (Hypertension)	☐ Yes	☐ No	Date _____
Blood Clots	☐ Yes	☐ No	Date _____
Heart Problems (murmers/surgery)	☐ Yes	☐ No	Date _____
Stroke or Stroke-like Problems	☐ Yes	☐ No	Date _____
Elevated Blood Sugar (Diabetes)	☐ Yes	☐ No	Date _____
Neurologic Problems (Epilepsy)	☐ Yes	☐ No	Date _____
Thyroid Problems	☐ Yes	☐ No	Date _____
Liver Disease (Hepatitis)	☐ Yes	☐ No	Date _____
Gallbladder Problems	☐ Yes	☐ No	Date _____
Stomach Problems (Ulcers)	☐ Yes	☐ No	Date _____
Bladder Problems (Incontinence)	☐ Yes	☐ No	Date _____
Bowel Problems (Colitis)	☐ Yes	☐ No	Date _____
Kidney Disease (UTI)	☐ Yes	☐ No	Date _____
Lung Disease (TB, Asthma)	☐ Yes	☐ No	Date _____
Breast Disease	☐ Yes	☐ No	Date _____
Cancer	☐ Yes	☐ No	Date _____
Anemia/Sickle Cell Anemia	☐ Yes	☐ No	Date _____
Psychiatric Problems	☐ Yes	☐ No	Date _____
Other	☐ Yes	☐ No	Date _____

B. GYNECOLOGIC HISTORY:

Menstrual History: (if in menopause, skip to next section)

1. The first day of my last menstrual period (date): _____
2. My period usually comes every _____ days (example: once a month = 28 – 30 days)
3. When I have my period, it usually lasts _____ days.
4. Do you have any problems related to your period? ☐ No ☐ Yes

   If yes, please explain _____
5. Do you have pain/cramps with your period? ☐ No ☐ Yes
6. How old were you when you had your first period? _____

Menopausal History:

1. Year menopause began (date of your last period): _____
2. Any bleeding since menopause? ☐ No ☐ Yes
3. Any problems with the following?

Vaginal Dryness	☐ No	☐ Yes
Hot Flashes	☐ No	☐ Yes
Urination	☐ No	☐ Yes
Bowel Movement	☐ No	☐ Yes

General Gynecology History:

1. Are you sexually active? ☐ No ☐ Yes
2. Do you have other symptoms or problems related to sex? ☐ No ☐ Yes Explain _____

Please continue questions on the back of this form ⟶

3. Age at first intercourse? _____
4. Current method of birth control _____
5. What other methods of birth control have you used? _____
6. Have you ever had any of the following? (check all that apply)

☐ Trichomonas ☐ Herpes ☐ Condyloma (genital warts) ☐ HIV ☐ Herpes
☐ Gonorrhea ☐ Syphilis ☐ Bacterial Vaginitis ☐ Chlamydia

7. Have you ever had an infection of the uterus, tubes or ovaries? ☐ No ☐ Yes
8. Have you ever had any of the following? (check all that apply)

☐ History of gynecological disease such as fibroids, endometriosis, etc. Explain _____
☐ Abnormal mammogram Date _____ ☐ Abnormal pap smear Date _____
☐ Colonoscopy Date _____ ☐ Cryotherapy Date _____
☐ LEEP Date _____

9. Date of last pap smear? _____ Result _____
10. Date of last mammogram? _____ Result _____ Location _____

C. OBSTETRICAL HISTORY: Please list all pregnancies.

Year	Vaginal or C-Section	Miscarriage	Abortion	Boy or Girl	Problems/Complications	Hospital Name

D. SURGERY AND HOSPITALIZATION HISTORY:

Year	Surgery	Hospitalization	Problem(s)

E. SOCIAL HISTORY:

Do you				
Smoke	☐ No	☐ Yes	Amt/Day ____	# years use ____
Drink Alcohol	☐ No	☐ Yes	Amt/Day ____	# years use ____
Use Illicit/Recreational Drugs	☐ No	☐ Yes	Amt/Day ____	# years use ____
Exercise Regularly	☐ No	☐ Yes	How often _____	
Have a history of abuse?	☐ No	☐ Yes	Type of abuse _____	

F. FAMILY MEDICAL HISTORY:

Do any of your relatives have the following?

Medical Illness	Yes	No	Maternal (Mom's side)	Paternal (Dad's side)
Cancer				
Diabetes				
Heart Disease				
Stroke				
High Blood Pressure				
Thyroid Disease				
High Cholesterol				
Kidney Disease				
Hepatitis				
Tuberculosis				
Bleeding Disorder				
Other				

By signing below, I certify the information I have provided to Hawaii Women's Healthcare is accurate and complete to the best of my knowledge.

Patient's Signature _____ Date _____

Physician's Signature _____ Date _____

☐ Cheryl Lynn T. Rudy, M.D. ☐ Cheryl Leialoha, M.D. ☐ Erin C. Gertz, M.D. ☐ Laura A. Spector, D.O. X Andrea Wieland, APRN

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HIPAA Patient Privacy Acknowledgement Form

I consent to the use or disclosure of my protected health information by Andrea Wieland, APRN for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Andrea Wieland, APRN. I understand that diagnosis or treatment of me by Andrea Wieland, APRN may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Andrea Wieland, APRN is not required to agree to the restrictions that I may request. However, if Andrea Wieland, APRN agrees to the restriction that I request, the restriction is binding on Andrea Wieland, APRN

I have the right to revoke this consent, in writing, at any time, except to the extent that Andrea Wieland, APRN has taken action in reliance on a government agency directive as outlined in the Notice of Privacy Practices.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

By signing this form, you acknowledge receipt of the Notice of Privacy Practices from Hawaii Women's Healthcare, LLC. The Notice of Privacy Practices provides information about how we may use and disclose your protected health information. Please read it carefully. The Notice of Privacy Practices is subject to change. If the Notice is changed, you may obtain a revised copy by visiting our website or upon request from our staff.

I acknowledge receipt of the Notice of Privacy Practices from Hawaii Women's Healthcare, LLC.

_____ _____

Signature of Patient or Legal Representative (Parent) Date

_____

Print Name of Patient and Print Name of Legal Representative

_____

Description of Legal Representative's Authority