

Absolutely no symptoms at all

Constitutional	Yes	No	Respiratory	Yes	No	Endocrine-General	Yes	No
fatigue	<input type="radio"/>	<input type="radio"/>	cough	<input type="radio"/>	<input type="radio"/>	increased water intake	<input type="radio"/>	<input type="radio"/>
fever	<input type="radio"/>	<input type="radio"/>	coughing blood	<input type="radio"/>	<input type="radio"/>	intolerance to heat or cold	<input type="radio"/>	<input type="radio"/>
weight gain	<input type="radio"/>	<input type="radio"/>	dyspnea / shortness of breath	<input type="radio"/>	<input type="radio"/>	Endocrine-Menstrual	Yes	No
weight loss	<input type="radio"/>	<input type="radio"/>	respiratory infections	<input type="radio"/>	<input type="radio"/>	having periods/using birth control	<input type="radio"/>	<input type="radio"/>
Psychological	Yes	No	tuberculosis	<input type="radio"/>	<input type="radio"/>	(answer questions below only if yes)		
alcoholism	<input type="radio"/>	<input type="radio"/>	wheezing	<input type="radio"/>	<input type="radio"/>	anxiety / tension	<input type="radio"/>	<input type="radio"/>
anxiety	<input type="radio"/>	<input type="radio"/>	Breast	Yes	No	appetite changes / food cravings	<input type="radio"/>	<input type="radio"/>
depression	<input type="radio"/>	<input type="radio"/>	change in breast skin	<input type="radio"/>	<input type="radio"/>	bloating	<input type="radio"/>	<input type="radio"/>
emotional problems	<input type="radio"/>	<input type="radio"/>	lumps	<input type="radio"/>	<input type="radio"/>	breast tenderness / swelling	<input type="radio"/>	<input type="radio"/>
hallucinations	<input type="radio"/>	<input type="radio"/>	nipple discharge	<input type="radio"/>	<input type="radio"/>	concentration problems	<input type="radio"/>	<input type="radio"/>
nervousness	<input type="radio"/>	<input type="radio"/>	tenderness	<input type="radio"/>	<input type="radio"/>	constipation / diarrhea	<input type="radio"/>	<input type="radio"/>
previous psychiatric care	<input type="radio"/>	<input type="radio"/>	Gastrointestinal	Yes	No	cramping	<input type="radio"/>	<input type="radio"/>
sleep disturbances	<input type="radio"/>	<input type="radio"/>	abdominal pain	<input type="radio"/>	<input type="radio"/>	depression / feelings of sadness	<input type="radio"/>	<input type="radio"/>
Skin	Yes	No	abnormal stools	<input type="radio"/>	<input type="radio"/>	fatigue	<input type="radio"/>	<input type="radio"/>
abnormal mole(s)	<input type="radio"/>	<input type="radio"/>	burping	<input type="radio"/>	<input type="radio"/>	headache / backache	<input type="radio"/>	<input type="radio"/>
acne	<input type="radio"/>	<input type="radio"/>	constipation	<input type="radio"/>	<input type="radio"/>	irritability or hostile behavior	<input type="radio"/>	<input type="radio"/>
changes in hair growth	<input type="radio"/>	<input type="radio"/>	diarrhea	<input type="radio"/>	<input type="radio"/>	libido reduced	<input type="radio"/>	<input type="radio"/>
itching	<input type="radio"/>	<input type="radio"/>	difficulty swallowing	<input type="radio"/>	<input type="radio"/>	low tolerance for noise / light	<input type="radio"/>	<input type="radio"/>
lesion(s)	<input type="radio"/>	<input type="radio"/>	flatulence	<input type="radio"/>	<input type="radio"/>	mood swings	<input type="radio"/>	<input type="radio"/>
nail changes	<input type="radio"/>	<input type="radio"/>	heartburn	<input type="radio"/>	<input type="radio"/>	sleep disturbances	<input type="radio"/>	<input type="radio"/>
rash	<input type="radio"/>	<input type="radio"/>	hemorrhoids	<input type="radio"/>	<input type="radio"/>	Endocrine-Menopausal	Yes	No
Eyes	Yes	No	poor appetite	<input type="radio"/>	<input type="radio"/>	experiencing menopausal symptoms	<input type="radio"/>	<input type="radio"/>
blind spots	<input type="radio"/>	<input type="radio"/>	rectal bleeding	<input type="radio"/>	<input type="radio"/>	(answer questions below only if yes)		
irritation	<input type="radio"/>	<input type="radio"/>	vomiting	<input type="radio"/>	<input type="radio"/>	anxiety / tension	<input type="radio"/>	<input type="radio"/>
vision changes	<input type="radio"/>	<input type="radio"/>	vomiting blood	<input type="radio"/>	<input type="radio"/>	concentration problems	<input type="radio"/>	<input type="radio"/>
Ear-Nose-Throat	Yes	No	Musculoskeletal	Yes	No	depression / feelings of sadness	<input type="radio"/>	<input type="radio"/>
headaches	<input type="radio"/>	<input type="radio"/>	back pain	<input type="radio"/>	<input type="radio"/>	hot flashes	<input type="radio"/>	<input type="radio"/>
lightheadedness	<input type="radio"/>	<input type="radio"/>	joint pain	<input type="radio"/>	<input type="radio"/>	irritability	<input type="radio"/>	<input type="radio"/>
neck pain	<input type="radio"/>	<input type="radio"/>	limitation of motion	<input type="radio"/>	<input type="radio"/>	night sweats	<input type="radio"/>	<input type="radio"/>
nose bleeding	<input type="radio"/>	<input type="radio"/>	muscle weakness	<input type="radio"/>	<input type="radio"/>	vaginal dryness	<input type="radio"/>	<input type="radio"/>
Hematology-Lymphatic	Yes	No	Genitourinary	Yes	No	weight gain	<input type="radio"/>	<input type="radio"/>
bleeding disorder	<input type="radio"/>	<input type="radio"/>	abnormal bleeding	<input type="radio"/>	<input type="radio"/>	Endocrine-Sexual	Yes	No
lymph node enlargement/tenderness	<input type="radio"/>	<input type="radio"/>	hematuria	<input type="radio"/>	<input type="radio"/>	decreased libido	<input type="radio"/>	<input type="radio"/>
previous transfusions and reactions	<input type="radio"/>	<input type="radio"/>	kidney stones	<input type="radio"/>	<input type="radio"/>	dyspareunia	<input type="radio"/>	<input type="radio"/>
Cardiovascular	Yes	No	nocturia	<input type="radio"/>	<input type="radio"/>	orgasmic dysfunction	<input type="radio"/>	<input type="radio"/>
chest pain	<input type="radio"/>	<input type="radio"/>	painful urination	<input type="radio"/>	<input type="radio"/>	Neurologic	Yes	No
fainting	<input type="radio"/>	<input type="radio"/>	urinary frequency	<input type="radio"/>	<input type="radio"/>	convulsions	<input type="radio"/>	<input type="radio"/>
heart murmur	<input type="radio"/>	<input type="radio"/>	urinary incontinence	<input type="radio"/>	<input type="radio"/>	difficulties with memory / speech	<input type="radio"/>	<input type="radio"/>
palpitations	<input type="radio"/>	<input type="radio"/>	urinary infections	<input type="radio"/>	<input type="radio"/>	incoordination	<input type="radio"/>	<input type="radio"/>
phlebitis	<input type="radio"/>	<input type="radio"/>	urinary urgency	<input type="radio"/>	<input type="radio"/>	paralysis	<input type="radio"/>	<input type="radio"/>
shortness of breath with waking at night	<input type="radio"/>	<input type="radio"/>	vaginal discharge	<input type="radio"/>	<input type="radio"/>	sensory or motor disturbances	<input type="radio"/>	<input type="radio"/>
shortness of breath with exercise	<input type="radio"/>	<input type="radio"/>	vaginal/vulvar itching	<input type="radio"/>	<input type="radio"/>	tremors	<input type="radio"/>	<input type="radio"/>
swelling	<input type="radio"/>	<input type="radio"/>	venereal disease	<input type="radio"/>	<input type="radio"/>			
varicosities	<input type="radio"/>	<input type="radio"/>						

Here at The Women's Health Institute, we understand how important your time is. We work hard to minimize our patient wait times and to keep our office running on schedule. Please be aware of the following policies and fees:

Any co-pays, out of pocket expenses or current balances must be paid at check-in, prior to your appointment. If you arrive without any means to pay, we will cancel your appointment and ask you to reschedule (a \$25 cancellation fee will be applied to your account).

Office Fees:

- \$25 cancellation fee will be applied to your account if you cancel your appointment with less than 1 business day of your appointment time.
- \$50 missed appointment fee will be applied to your account if you do not show up for your appointment.
- \$25 late fee will also be applied to your account if you arrive more than 10 minutes late but can still be seen.
- \$50 late fee will also be applied to your account if you arrive more than 10 minutes and have to reschedule your appointment.
- \$25* minimum NSF fee + bank charges will be applied to your account for checks received that do not clear at your bank. *(depending on face value can be up to 5%)
- \$25 late fee for overdue balances on your account.
- \$150 cancellation fee will be applied to your account if you have a surgery scheduled and notify our office of your intent to cancel less than 2 weeks before your planned surgery.
- \$300 cancellation fee will be applied to your account if you have a surgery scheduled and notify our office of your intent to cancel with less than 1 week before your planned surgery.
- \$500 missed surgery fee will be applied to your account if you have a surgery scheduled and do not show up for your surgery or if you cancel with less than one business day's notice or if the surgery must be cancelled due to your not following pre-surgery preparation protocols.
- \$25 per form to prepare (FMLA, Short Term Disability paperwork, etc.), payable in advance.
- \$1 per sheet (\$0.25 per sheet after first 25) to supply copies of your medical records

If you are having lab work undertaken by The Women's Health Institute, please ensure that we have your correct and up-to-date personal and insurance information. Should any of the information we provide the lab be incorrect, we cannot be held responsible for any charges you receive from the third party laboratories we use.

Depending on the type of insurance you have and the particular plan you participate in, we find widely varying co-pay, co-insurance, and other out-of-pocket expenses exist from patient to patient. As a courtesy to all our patients we routinely process charges to your insurance carriers on your behalf but there are no guarantees we will always be paid for the services provided.

Any patient balances will be processed and invoices mailed out to the address we have on file for you within one (1) calendar month. Payment of these balances is expected upon receipt of this statement. Your balance can be paid by check, credit or debit card in the mail or using your credit or debit card by telephoning our offices at (561) 784-1933 (option 2). If you are unable to settle your balance, please call our office for assistance in remedying the matter.

If we do not hear from you within one month of your first invoice, we will apply the late fee to your account and send you a reminder statement. During this time period, we will make reasonable attempts to contact you. If we do not receive any payment within these two billing cycles, your last invoice will arrive with a notice explaining our intent to send your account to collections. Typically, you will receive a 10 day grace period at this time and an explanation that we will apply any fees associated with the collection agency to your account. This amount will vary but will often be 33-50% of the account total. Patients who are sent to collections will be discharged from the practice.

Please read and sign below:

I have read and understand the information provided by this form. I understand my responsibilities and the fees that may be incurred if I am unable to meet them.

Patient / Legal Guardian Signature_____
Print Name and Relation to Patient_____
Date



Credit Card On File Authorization

10131 Forest Hill Blvd, Suite 130 • Wellington, FL 33414 • 561.784.1933 • fax: 561.784.5109 • TheWHI.com

Credit card authorization for charges incurred by the following patients:

Patient Name _____ Date of Birth: ____/____/____

Patient Name _____ Date of Birth: ____/____/____

Patient Name _____ Date of Birth: ____/____/____

I am authorizing The Women's Health Institute of Wellington, LLC to charge my credit card for any and all charges due for the above listed patients. I am authorizing The Women's Health Institute of Wellington, LLC to charge my credit card for the full amount due. I will not dispute charges for sessions that have been performed or for any appropriate fee billed based upon the current The Women's Health Institute fee policy. Fees will be charged for patient sessions, no-shows, cancellations without appropriate notice, and other appropriate services. I further authorize The Women's Health Institute of Wellington, LLC to disclose information pertinent to the above listed patients' activities which have been charged, if necessary.

Card Type: Visa MasterCard Discover American Express Care Credit

Card #: _____ Sec Code: _____ Exp Date: ____/____/____

Name on card: _____

Billing Address: _____

I affirm to be an authorized user of the above listed credit card understanding that it is my responsibility to notify The Women's Health Institute of Wellington, LLC of any circumstances that could affect this agreement (lost or stolen card, new expiration date, new billing address, credit limit reached, card cancelled, etc.)

Cardholder's Signature: _____ Date: ____/____/____

This form will be securely stored and may be updated upon request at any time.

Please note, your credit card will **not** be charged unless one of above-listed patients incurs a charge without payment being rendered at that time.