Western Carolina Women's Specialty Center

AN AFFILIATE OF MISSION HEALTH

WESTERN CAROLINA WOMEN'S SPECIALTY CENTER, PA welcomes you to our practice. The physicians and staff of our practice are committed to serving you by providing high-quality, personal and effective gynecologic care. Thank you for your confidence in us and allowing us to help with your medical care. The experienced, board-certified gynecologists in this practice provide expert care with full preventative, diagnostic and therapeutic options for women. Special areas of expertise include urogynecology, breast medicine, adolescent health and menopause.

We have 5 Physicians and 1 Family Nurse Practitioner:

Dr. James Theofrastous	Dr. Megan Daw
Dr. Nancy Howden	Dr. Sarah Bradley
Dr. Michelle LeBlanc	Kathryn Usedom, MSN, CNM, FNP-C

Your appointment is scheduled with Dr. Michelle LeBlanc on _____ at _____. Please arrive 30 minutes prior to your scheduled appointment time to allow time for the paper work to be processed. Also, please have your insurance card(s) with you or you will be rescheduled.

MICHELLE A. LEBLANC, M.D.

Dr. LeBlanc graduated from Rice University and the University of Texas Medical School in Houston. She fulfilled her residency training at MAHEC in Asheville, NC. She specializes in benign and malignant breast conditions. She provides a full range of diagnostic and treatment options for breast conditions, including breast ultrasound, minimally invasive stereotactic biopsy, breast conserving procedures and open surgical biopsies.

OFFICE HOURS AND APPOINTMENTS

Routine office hours are 8:00 a.m. to 5:00 p.m. Monday-Thursday and 8:00 a.m. to 1:30 p.m. on Fridays. **Patients are seen by appointment only.** Every effort is made to maintain a timely schedule. Patients are asked to arrive 30 minutes before their scheduled appointment time. If you are delayed for any reason, please call us at (828) 670-5665. You may be asked to reschedule depending on the schedule.

NIGHTS AND WEEKENDS

The office telephone (828) 670-5665 is answered outside of routine office hours for emergencies. The answering service will take your name and phone number and the on-call physician will return your call.

TELEPHONE CALLS

For problems, questions or prescription refills, call the office between 8:00 a.m. and 4:30 p.m. Monday-Thursday and 8:00 a.m. and 1:30 p.m. on Fridays. If your call is concerning a medical problem or lab results, the nurse will consult with your physician and return your call as soon as possible. If your call requires an urgent response, please make this clear to our staff. Non urgent calls received after 12:00 p.m. may not be returned until the following business day. Please allow 2 business days for refills.

MEDICAL IDENTITY THEFT PROGRAM

Western Carolina Women's Specialty Center, P.A. complies with the Identity Theft Prevention Program. We have implemented some office procedures to help protect you from being a victim of medical identity theft.

As a new patient on your first visit you will be asked for a photo I.D. (ex: driver's license, work I.D.) with your name on it. If you do not have a photo I.D. you will be asked for two other forms of identity with your name on them.

FINANCIAL POLICY

Your insurance contract is an agreement between you, your insurance company and, in many cases, your employer. All charges incurred at Western Carolina Women's Specialty Center, P.A. are your responsibility. Any disputes with the insurance company should be handled by you. As a courtesy to you, we will file a claim with your insurance company(s). We participate with most insurance companies. You can contact Mission Health Central Billing Office at 833-323-0837 with questions regarding your insurance company.

Payment is required when services are rendered. In the instance where there is a co-pay, the co-pay will be collected at time of service or you will be rescheduled. Patients that have no insurance are expected to pay all fees associated with the visit at the time of service. If you feel you need financial assistance you can contact the Mission billing office at 828- 213-1500.

If you require a disability form or FMLA papers to be completed, the first one is free, any after that will be charged at $35 each.

Our fees reflect our expertise as well as the time spent with the physician and staff and the time spent reviewing your medical record, labs, and communicating with other physicians involved in your care.

SUMMARY

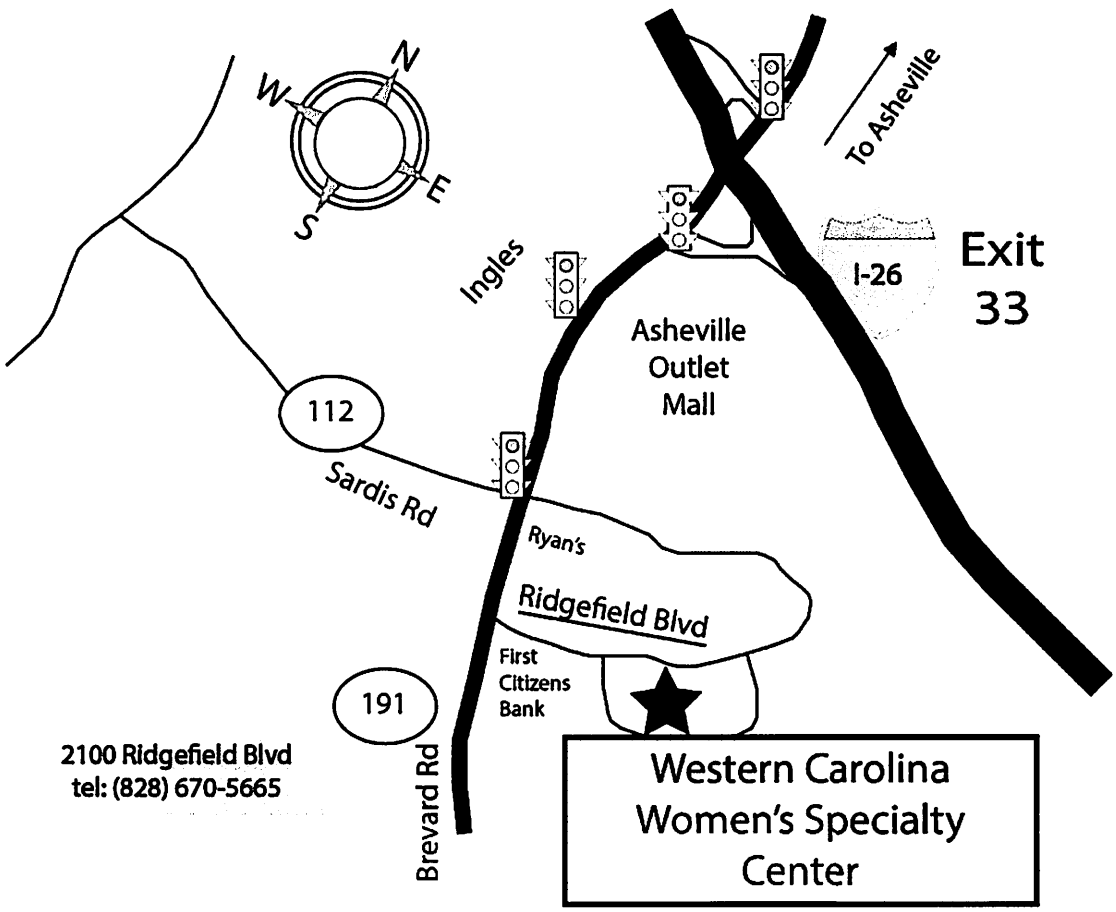
The physicians and staff at Western Carolina Women's Specialty Center, P.A. are committed to serving you by providing high-quality, personal and effective gynecologic care. We hope you will always feel free to discuss your problems with us, and we welcome any suggestions that might lead to better service on our part. Thank you for your confidence in us.

Please visit our website www.wcwsc.com for more information.

LOCATION

***From I-26:** Take Exit 33 to Brevard Road (191 South). Go past Asheville Outlet Mall and Ryan's/K-Mart Plaza, turn left at Ridgefield Blvd just before First Citizens Bank. We are located right behind First Citizens Bank on your right.

***From Brevard Road (191 South):** Take a right onto Ridgefield Blvd just beyond First Citizens Bank. We are located right behind the bank on your right.



NOTICE OF PRIVACY PRACTICES

Western Carolina Women's Specialty Center, PA

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
Please review it carefully.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care provider. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer.

- The right to request restrictions on certain uses and disclosures of personal health information, including disclosures to someone involved in your care or payment for your care, like a family member or friend. **We are not required to agree with your request.** If we do agree, we will comply unless this information is needed to provide you emergency treatment.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office. You have recourse if you feel that your privacy protections have been violated. You have a right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

For more information about HIPAA or to file a complaint:

The US Dept of Health and Human Services Office of Civil Rights
200 Independence Ave, SW Washington, DC 20201 (202) 619-0257 or 1-877-696-6775.

Western Carolina Women's Specialty Center Patient Intake History

Name: _____ **Age:** ___ **Date of Birth:** ___/___/___ **Visit Date:** ___/___/20___

Reason for today's visit: _____

Referring MD: _____ **Primary MD:** _____

Medications: _____

_____

Pharmacy: _____

Calcium Supplement: ☐ none_____mg/day **Vitamin D Supplement:** ☐ none _____IU/day **Multivitamin:** ☐

Drug Allergies: ☐ none _____

Medical Conditions: ☐ none ☐ abnormal pap smear: year_____ treatment _____

☐ Anxiety ☐ Depression ☐ Heart attack: Year _____ ☐ High cholesterol ☐ Osteoporosis
☐ Arthritis ☐ Diabetes ☐ Heart murmur ☐ Irregular heart beat ☐ Stomach ulcer
☐ Asthma ☐ Diverticulosis ☐ Hepatitis/liver disease ☐ Irritable bowel ☐ Stroke: Year _____
☐ Bipolar ☐ Emphysema ☐ High blood pressure ☐ Kidney stone ☐ Thyroid
☐ Blood clot: Year _____ Treatment _____
☐ Breast problem: _____
☐ Cancer - ☐ Breast ☐ Cervix ☐ Colon ☐ Ovary ☐ Uterus ☐ Other: _____
Treatment: _____
Other medical problems: _____

Past Surgery: ☐ no major surgery
☐ Hysterectomy - Year _____ ☐ vaginal ☐ abdominal ☐ one ovary removed ☐ both ovaries removed
☐ Bladder control surgery – Year _____ ☐ vaginal ☐ abdominal ☐ breast - _____
☐ Gall bladder ☐ tonsils ☐ hip replacement ☐ knee replacement
Other surgeries: _____

Gynecologic History: Last menstrual period _____ **Obstetric History:** Number of pregnancies _____
Age at 1st menstrual cycle: _____ Number of vaginal deliveries _____ C-sections _____
☐ My cycles are regular every ____days, & last ___ days Weight of largest child _____lbs ____ oz
☐ My cycles are irregular every ____ to ____ days ☐ Tear into rectum
☐ My cycles stopped in _____ ☐ No hormone therapy ☐ hormones since: _____ ☐ Used hormones for ____ years

Contraception: ☐ none ☐ birth control pills ☐ tubal ☐ vasectomy ☐ not sexually active

Family History: Please note which family member(s) & age of the condition
☐ Cancer: Breast - _____ ☐ Cancer: Cervix- _____ ☐ Cancer: Ovary -_____
☐ Cancer: Uterus - _____ ☐ Cancer: Colon - _____ ☐ Cancer: Other - _____
☐ Diabetes - _____ ☐ Heart attack - _____ ☐ Stroke - _____
☐ Osteoporosis - _____

Social History:
Marital status: ☐ single ☐ married ☐ widowed ☐ male partner ☐ female partner
Lives with: ☐ self ☐ spouse ☐ significant other ☐ children ☐ friend ☐ assisted care
Occupation: _____ ☐ do not work outside the home ☐ retired from: _____
Education: ☐ elementary school ☐ high school ☐ college ☐ postgraduate - _____
Exercise: ☐ none ☐ rare ☐ regular (2-3 times/week) ☐ several times/week
Type of exercise: ☐ walk ☐ other: _____
Tobacco use: ☐ none ☐ former-quit ____yrs ago ☐ _____pack/day for ___ years
Alcohol use: ☐ none _____drinks per week
Recreational drug use: ☐ none _____usage

Please answer below the most recent screening tests:

Test	Year	Normal	Abnormal	Test	Year	Normal	Abnormal
Bone Density				Cholesterol			
Colonoscopy				Mammogram			
Pap Smear							

Account #: _____ SSN: _____ Home #: _____
Last Name: _____ Suffix: _____ Work #: _____
First Name: _____ Preferred Name: _____ Cell #: _____
Middle: _____ Marital Status: _____ Gender: _____
Address: _____ Employment: ❑ FT ❑ PT Date of Birth: _____
Address: _____ Student: ❑ FT ❑ PT
City: _____ State: _____ Zip Code: _____
Email: _____ Employer: _____
Primary Care Doctor: _____

HIPAA Contact Information - *these contacts are authorized to give/receive medical and financial information*

Name	Relationship	Contact Info (Phone #)

Guarantor Information (Responsible for Bill) Gender: _____ Date of Birth: _____ SSN: _____

Guarantor Name

_____ _____ _____ _____

First Middle Last Home Phone Work Phone Cell Phone

Mailing Address: _____ City, State, Zip: _____

If you do not have insurance, please answer the questions below:	Yes	No
1. Is the patient under the age of 21?	❑	❑
2. Is there anyone living in the patient's home under the age of 19?	❑	❑
3. Is the patient pregnant?	❑	❑
4. Is the patient currently receiving Social Security Disability benefits?	❑	❑
5. Does the patient currently have a disability or Medicaid Application pending?	❑	❑
6. Does the patient identify as having a disability?	❑	❑

Meaningful Use Information
Race: _____ Ethnicity: _____ Language: _____

Rural Health: *Please circle all that apply* Homeless: T / F Veteran: T / F
Migrant: T / F Seasonal: T / F

If you provide your insurance card(s), you do not have to complete this section:

Insurance Information - PRIMARY
Subscriber's Relationship to Patient: _____
Subscriber Name: _____ DOB: _____ Certificate #: _____
Insurance Carrier: _____ Claims Mailing Address: _____
Group Name: _____ City, State, Zip: _____
Group #: _____ Phone Number: _____

Insurance Information - SECONDARY
Subscriber's Relationship to Patient: _____
Subscriber Name: _____ DOB: _____ Certificate #: _____
Insurance Carrier: _____ Claims Mailing Address: _____
Group Name: _____ City, State, Zip: _____
Group #: _____ Phone Number: _____

Emergency Contacts

Name	Relationship	Contact Info (Phone #)

MHA-00000-345-0916

MISSION
HEALTH AFFILIATE

Ambulatory Registration Form