Women's Medical Center of Meridian, P.A.
MISSION STATEMENT

The mission at Women's Medical Center of Meridian, P.A. is to provide quality healthcare to our women patients, while employing the highest ethical standards and complying with the laws and regulations that govern the delivery of that care. We want our devotion to these ideals to inspire confidence in our patients as well as our medical staff. To accomplish this end we have on staff two of the best trained physicians in Meridian.

Daniel J. McKiever, Jr., M.D., F.A.C.O.G., who is Board Certified, received his medical degree from the University of Alabama-Birmingham School of Medicine and performed his OB/GYN Residency at the University of Florida School of Medicine. Dr. McKiever is expertly trained in gynecological and obstetrical care employing state of the art medical treatments and surgical procedures including high-risk surgery.

Our supporting staff of experienced nurses and technicians strive to make each patient's visit a positive experience. Women's Medical Center of Meridian, P.A., has been caring for every stage of women's health since 1993. We are dedicated to diagnosing accurately every medical need and providing the most appropriate treatment for each individual patient.

The patients who are in our office, in the hospital, or patients who call in with an emergency, are given priority attention. Patient medication refills will be called in within 48 hours, so please check with your pharmacy first, and all non-emergency phone calls will be returned within 24 hours.

Signature: _____

Patient # _____

Please fill out each blank that applies. Mark N/A if not applicable.

Primary Care Physician _____ Referring Physician _____

PATIENT INFORMATION

Last Name _____ First Name & MI_____

Date of Birth _____ SSN _____

Mailing Address _____

Physical Address (if different) _____

City, State, & Zip _____

Home Phone _____ Cell Phone _____

Patient's E-Mail Address _____

Marital Status (circle one) Married Single Divorced Widowed

Patient Employer _____ Work Phone _____

Employer's Address _____

SPOUSE OR LEGAL GUARDIAN INFORMATION

Their First Name _____ MI_____ Last Name_____
Address (if different from patient's) _____
Their Phone _____ Their Date of Birth _____

PRIMARY INSURANCE

Name of Person Who Carries Insurance _____
Insurance Carrier's Relationship to Patient (circle one) Spouse Parent Self
Name of Insurance Company_____
Insurance ID # _____ Group # _____
Employer of Person Who Carries Insurance _____
(MANDATORY) Date of Birth of Person Who Carries Insurance _____
(MANDATORY) SSN of Person Who Carries Insurance _____

SECONDARY INSURANCE (if applicable)

Name of Insurance Company_____
Name of Person Who Carries Insurance _____
Insurance Carrier's Relationship to Patient (circle one) Spouse Parent Self
Insurance ID # _____ Group # _____
Employer of Person Who Carries Insurance _____
(MANDATORY) Date of Birth of Person Who Carries Insurance _____
(MANDATORY) SSN of Person Who Carries Insurance _____

ALTERNATIVE CONTACTS – THIS SECTION IS MANDATORY

Please list someone other than your spouse.

1)_____ _____ _____
Contact Name **Primary Phone** **Secondary Phone**

2) _____ _____ _____
Contact Name **Primary Phone** **Secondary Phone**

PATIENT CONTACT INFORMATION SHEET

Women's Medical Center of Meridian, P.A.

Patient Name: _____ DOB: _____

Social Security #: _____

Any physician, staff member, employee, or representative of WOMEN'S MEDICAL CENTER OF MERIDIAN, P.A., has my permission to discuss my account and medical conditions, which may include symptoms, treatments, diagnoses, test results, medications, or any other types of protected health information, with the following persons in order to facilitate and coordinate my care, treatment, and payment:

Name	Relationship to Patient	Phone Number(s)
Name	Relationship to Patient	Phone Number(s)
Name	Relationship to Patient	Phone Number(s)
Name	Relationship to Patient	Phone Number(s)

I understand that authorizing the release of my information to the above individual(s) is voluntary and does not affect my access to treatment. I can refuse to sign this form. I can revoke it by writing to WOMEN'S MEDICAL CENTER OF MERIDIAN, P.A., or completing a new form at any time. This authorization will remain in effect until I change or revoke it. I understand that if information is shared with the above individual(s), it may be subject to redisclosure by the individual(s).

Patient Signature: _____ Date: _____

☐ Copy available to patient upon request.

COMPLETE THIS FORM BEFORE EACH APPOINTMENT.

Today's Date: _____

Print Name: _____

Date of Birth: _____

Referred by: _____

Reason for visit: _____

Review of Systems:

Are you tired all the time?……..…….....	Y	N
Do you have night sweats?……...	Y	N
Do you have fever, chills, or body aches?……...	Y	N
Have you had any weight loss or weight gain? ……..	Y	N
Do you have headaches, vertigo, light-headedness, or nosebleeds?…….…...	Y	N
Do you have any dental problems?……..	Y	N
Do you have a stiff neck or thyroid mass?……..….	Y	N
Do you have breast lumps, tenderness, swelling, or nipple discharge?…….…..	Y	N
Do you have chest pains, irregular heartbeat, rapid heartbeat, or leg swelling?……..	Y	N
Do you have shortness of breath, wheezing, cough, or hoarseness?……	Y	N
Do you have nausea, vomiting, diarrhea, excessive belching, or abdominal pain?	Y	N
Is there ever blood in your stools or do you have hemorrhoids?…….……	Y	N
Do you have difficulty with frequent urination, or have changes in urine color or odor?……..	Y	N
Do you have rashes, itching, new skin lesions, or changes in existing moles or acne?……...	Y	N
Do you have muscular weakness, tingling, numbness, or terrors?……..	Y	N
Do you have seizures?……	Y	N
Do you have joint pain, swelling, muscle pain, limitation of motion, or back pain?……..	Y	N
Do you have anxiety or feel depressed?……..	Y	N
Have you ever been treated for anxiety or depression in the past?……..	Y	N
Do you have difficulty sleeping, impulsive behavior, or excessive anger?…….	Y	N
Do you have easy bleeding or bruising?……..	Y	N

Social History:

Are you (circle one) Married Single Divorced Widowed

Are you sexually active? Y N If you are not currently sexually active, have you ever been? Y N

How many partners have you had? _____

Have you ever had a pelvic infection or been told you have an STD? Y N

If so, which one(s)? _____

Do you smoke? Y N

If yes, how many packs/cigarettes per day? _____ How long have you smoked? _____

Do you drink alcohol? Y N Socially

Do you use any drugs of abuse? Y N If yes, which one(s)? _____

Do you go to school? Y N If so, where? _____

Do you work outside of the home? Y N If so, where? _____

MY MEDICATIONS

Name:	**Date:**
Date of Birth:	
Medication Allergies:	
Completed by: ☐ **Patient** ☐ **Family/Significant Other** ☐ **Nurse** ☐ **Friend**	

CURRENT MEDICATIONS:

1) Medications prescribed to me by my doctor

Medication	Dosage	How often do you take this?

2) Over-the-counter medications I take (ex. aspirin, Tylenol, vitamins, antacids, etc.):

Medication	Dosage	How often do you take this?

3) Herbal medications I take (ex. Staint-John's-wort, ginkgo biloba, ginseng, Zing, etc.)

Medication	Dosage	How often do you take this?

CERTIFICATION/AUTHORIZATION OF INSURED:

Women's Medical Center of Meridian, P.A.

1523 22nd Avenue
Meridian, MS 39301
601-483-0039

I certify the insurance information I have provided to the above office to be true and correct to the best of my knowledge. I authorize payment for services rendered to the doctors associated with the above office. I understand that the doctors cannot accept responsibility for collecting my insurance claim or for negotiating a settlement on a disputed claim. I am responsible for payment of my account in full within the terms of the above payment policy. If I am under 18, the parent/guardian requesting treatment assumes responsibility. I understand that if my account should ever require action by a collection agency in order to collect the balance owed, fees charged by this agency may be added to the balance due on my account.

I authorize the doctors and Women's Medical Center and its designees to provide treatment. I further authorize labs, radiology centers, pathologists, and radiologists who may interpret and report on diagnostic tests, and anesthesiologists who will administer anesthesia during a scheduled procedure, to provide such treatment, if such tests/procedures are ordered by my doctor(s). I authorize the above office to release all or part of my records to physicians to whom I am being referred and/or any inpatient or outpatient facility where I am scheduled to receive treatment..

I authorize the above office to use my name, address and phone number, the name of my scheduled treating physician, and the time and place of my scheduled appointment(s) for the limited purpose of contacting me to notify me of a pending appointment or other health care related communication. I also authorize the above office to disclose to third parties who answer my phone limited information regarding a pending appointment, and to leave a reminder message on my answering machine.

_____

Print Name

_____

Lifetime Signature

_____

Date

THIS FORM IS MANDATORY FOR ALL PATIENTS.

MEDICAID WAIVER FORM FOR ALL SERVICES

Women's Medical Center of Meridian, P.A.

Date: _____

Women's Medical Center will NOT ACCEPT Medicaid of Mississippi as secondary insurance for obstetrical care including delivery.

All patients WILL BE responsible for any non-covered services denied by Medicaid which are rendered by Women's Medical Center.

I _____ have read, understand, and agree to the above policy by Women's Medical Center. **I** will be responsible for any non-covered service denied by Medicaid or any service denied for medical necessity by Medicaid of Mississippi.

Patient Signature _____

Guardian Signature (if minor) _____

Witness_____

THIS WAIVER IS VALID FOR ALL DATES OF SERVICE.

ALL PATIENTS MUST COMPLETE AND SIGN THIS FORM EVEN IF YOU HAVE NO INTENTION OF USING MEDICAID AS A FORM OF PAYMENT.

PAYMENT AGREEMENT

Women's Medical Center of Meridian, P.A.

I do hereby confirm that all the information that I have supplied to Women's Medical Center of Meridian, P.A. (WMC), is true and correct, to the best of my knowledge.

I also agree to notify WMC of any changes in the information I have provided regarding either health status or general patient information, and changes in insurance information on a timely basis or upon my next scheduled appointment with WMC.

I hereby acknowledge that I am ultimately responsible for the full payment of any and all fees or charges for services provided to me by WMC, and that filing of insurance claims with any health care insurance coverage I may hold is a courtesy to me and does not in any way relieve me of financial responsibility for any balance remaining after insurance payments, **including any amount that exceeds my insurance company's usual, reasonable, and customary rate.**

I understand that WMC requires that **ALL BALANCES** be paid **IN FULL** within thirty (30) days of treatment. I also understand that if I disagree with the payment made by my insurance carrier, I will contact the carrier directly to discuss those concerns.

I understand that if my primary care physician has not authorized this visit and I have no referral number, the services I receive may not be covered by my health care benefits plan. In that case, I will be responsible for payment in full for services rendered. **(NOTE: This paragraph applies only to patients who require a referral number from their PCP.)**

I understand that my insurance plan may not cover certain procedures and that if I request non-covered services, I will be financially responsible for those services and agree to pay any and all non-covered fees and charges.

I am aware that my co-pay, co-insurance, and/or deductible is due at today's visit.

A $25 fee will be charged for missed appointments not canceled with your doctor's receptionist at least 24 hours before the appointment.

A $25 fee will be charged for all returned checks.

Should my account ever be turned over to a collection agency, I will be responsible for any and all collection costs, including attorney fees and any court costs.

_____ _____

Signature **Date**

Women's Medical Center of Meridian, P.A.

1523 22nd Avenue – Meridian, MS 39301
Phone: 601-483-0039 Fax: 601-485-7240

Daniel J. McKiever, Jr., M.D.

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH CARE INFORMATION TO WMC

_____ _____ _____
PATIENT NAME (please print) PATIENT SOCIAL SECURITY # PATIENT DATE OF BIRTH

I I hereby authorize the use or disclosure of my protected health information as described below.

Doctor/Organization to RELEASE Medical Records

_____
NAME OF DOCTOR FROM WHOM YOU ARE REQUESTING RECORDS

_____
ADDRESS OF DOCTOR/ORGANIZATION

_____
CITY STATE ZIP

_____
PHONE FAX

Doctor/Organization to RECEIVE Medical Records

WOMEN'S MEDICAL CENTER
NAME OF DOCTOR/ORG. TO RECEIVE YOUR RECORDS

1523 22nd Avenue
ADDRESS OF DOCTOR/ORGANIZATION

Meridian, MS 39301
CITY STATE ZIP

601-483-0039 601-485-7240
PHONE FAX

Disclose the following medical records for treatment dates _____ to _____:

_____ Entire Medical Records

_____ Other (specify): _____

_____

I acknowledge and hereby consent to such that the released information may contain alcohol and drug abuse, psychiatric or mental care/treatment, HIV, AIDS, STD test result, or genetic information.

I understand that I have the right to revoke this authorization at any time. I understand that I must do so in writing and present the written revocation to Women's Medical Center of Meridian, P.A. I understand that the revocation will not apply to information that has already been released as a result of this authorization.

If the requested or the receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may not be disclosed.

This authorization shall expire upon this expiration date: _____. If I fail to specify an expiration date, this authorization will expire six months from the date on which it was signed and dated.

I have read the above and authorize the disclosure of the protected health information as stated.

_____ _____
SIGNATURE OF PATIENT OR PARENT/LEGAL REPRESENTATIVE DATE

If signed by legal representative, relationship to the patient: _____

_____ _____
SIGNATURE OF WITNESS DATE