# The Woman's Care Center, PC

Marisol San Inocencio, M.D.
Keisha McEwen, M.D.
Jessica Hudson, N.P.C.
Jenifer Byrd, N.P.C.

*Obstetrics and Gynecology*

| PATIENT INFORMATION | | | | DATE |
|---|---|---|---|---|
| LAST NAME | FIRST NAME | | MI | DATE OF BIRTH |
| SOCIAL SECURITY # | MARITAL STATUS (Please Circle One) SINGLE MARRIED DIVORCED WIDOWED | | | PREFERRED PHARMACY |
| RACE | ETHNICITY (Please Circle one) HISPANIC OR LATINO NOT HISPANIC OR LATINO | | | |
| SPOKEN LANGUAGE | PREFERRED LANGUAGE | | | |
| MAILING ADDRESS | | | | APT # |
| CITY | STATE | ZIP | EMAIL ADDRESS | |
| HOME PHONE ( ) | CELL PHONE ( ) | | PREFERRED PHONE TO BE CALLED ON HOME CELL | |
| EMPLOYER/SCHOOL NAME | EMPLOYER /SCHOOL ADDRESS | | | |
| SPOUSE'S NAME | SOCIAL SECURITY # | DATE OF BIRTH | CELL PHONE ( ) | |

| INSURANCE INFORMATION | | | |
|---|---|---|---|
| PRIMARY INSURANCE COMPANY | | GROUP # | POLICY/ID # |
| ADDRESS TO MAIL CLAIMS | | INSURANCE COMPANY PHONE # | |
| NAME OF INSURED | DATE OF BIRTH | SOCIAL SECURITY # | RELATIONSHIP TO PATIENT |
| SECONDARY INSURANCE COMPANY | | GROUP # | POLICY/ID# |
| ADDRESS TO MAIL CLAIMS | | INSURANCE COMPANY PHONE # | |
| NAME OF INSURED | DATE OF BIRTH | SOCIAL SECURITY # | RELATIONSHIP TO PATIENT |

| EMERGENCY INFORMATION | | |
|---|---|---|
| EMERGENCY CONTACT NAME | EMERGENCY CONTACT PHONE # | RELATIONSHIP TO PATIENT |

| OTHER INFORMATION | | |
|---|---|---|
| REFERED TO OUR PRACTICE BY | | |
| PRIMARY CARE PHYSICIAN NAME | PRIMARY CARE PHYSICIAN ADDRESS | PRIMARY CARE PHYSICIAN PHONE # |

| AUTHORIZATION TO RELEASE INFORMATION | AUTHORIZATION TO PAY BENEFITS |
|---|---|
| I HEREBY AUTHORIZE THE WOMAN'S CARE CENTER TO RELEASE ANY MEDICAL INFORMATION NECESSARY TO PROCESS INSURANCE CLAIMS AND CERTIFY THAT THE ABOVE INFORMATION IS CORRECT | I HEREBY AUTHORIZE AND ASSIGN PAYMENT OF SURGICAL AND MEDICAL BENEFITS TO THE WOMAN'S CARE CENTER. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR CHARGES NOT COVERED BY THE ASSIGNMENT. |
| SIGNATURE OF INSURED | SIGNATURE OF RESPONSIBLE PERSON |

**FINANCIAL AGREEMENT: OUR OFFICE DOES NOT BILL PATIENTS FOR OFFICE VISITS OR COPAYS. PAYMENTS MUST BE MADE AT TIME OF VISIT. SIGNATURE:** _____

www.thewomanscarecenter.com
1001 Fernwood Drive • Milledgeville, Georgia 31061 • Telephone (478) 453-8100 • Fax (478) 453-4475

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*— Obstetrics and Gynecology —*

I AUTHORIZE:

_____
Name of sending person/organization

_____
Street Address

_____
City State Zip Code

TO RELEASE TO:

_____
Name of receiving person/organization

_____
Street Address

_____
City State Zip Code

**INFORMATION TO BE RELEASED:** (Check all applicable)

☐ All Information ☐ Progress Notes ☐ Lab Reports ☐ X-ray Reports
☐ Emergency Dep. Records ☐ History & Physical ☐ Operative Reports ☐ Other

**SPECIAL AUTHORIZATION:** Check applicable box(es) and sign immediately below.
By signing below, I am authorizing the office to release any and all information regarding:

☐ Alcohol ☐ Drugs ☐ Mental Health ☐ Sexually Transmitted Diseases ☐ HIV ☐ AIDS

**Note:** If this release pertains to alcohol, drug, or mental health information, please note that this information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of this information unless additional further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Patient's Signature: _____ Date: _____

**PURPOSE OF DISCLOSURE:** (Check applicable purpose)

☐ Continued Medical Care ☐ Payment of Insurance Claim ☐ Legal
☐ Personal ☐ Workers' Compensation Claim ☐ Other: _____

I understand that I may revoke this consent in writing at any time except to the extent that action has already been taken in reliance on this authorization. This authorization expires _____ (Not to exceed six months from the date of request)

I understand I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment. The undersigned authorizes The Woman's Care Center, P.C. to use and/or disclose protected health information as described above.

Signature of Patient or Patient's Authorized Representative _____

Relationship or Authority/Capacity to act on Patient's Behalf _____

Printed Name of Patient _____ Date of Birth _____

Home Phone: _____ Work Phone: _____

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***PERMISSION TO VERBALLY DISCUSS PROTECTED HEALTH INFORMATION***

| Patient Name | | Date of Birth |
|---|---|---|
| Patient Address | City, State | Zip |
| Patient Phone | | |

**I give permission to The Woman's Care Center to verbally discuss the following medical and billing information about me (check all that apply):**

_____Scheduling/Appointment information

_____Medical information, including my symptoms, diagnosis, medication and treatment plan

_____Behavioral health information, including my symptoms, diagnosis, medications and treatment plan

_____Chemical dependency information, including my symptoms, diagnosis, medications and treatment

_____Lab/test results

_____Billing and payment information

_____Other (describe)

**The Woman's Care Center has my permission to discuss the above information with:**

Name_____

Address_____

City, State, Zip_____

Home Phone_____ Cell Phone_____

Name_____

Address_____

City, State, Zip_____

Home Phone_____ Cell Phone_____

I understand that I have the right to revoke my permission at any time except where The Woman's Care Center has already made disclosure in reliance upon this request. **I understand that I must notify The Woman's Care Center in writing if I want to revoke my permission. (Initial_____)**

**Signature**_____ **Date**_____

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# The Woman's Care Center, PC

***PERMISSION TO VERBALLY DISCUSS PROTECTED HEALTH INFORMATION-INFORMATION SHEET***

The Woman's Care Center understands that privacy regulations have an impact on our customer service to you, especially when it comes to discussing information about you with family, friends and others you designate who are involved in your care. We have established a process that allows you to tell us who we may talk to about your personal care.

**How can I give others permission to get verbal information about me?**
Complete the Permission to Verbally Discuss Protected Health Information form to let us know to whom we may discuss your health information with.

**How is the information on the form used?**
Anytime your designated person calls or makes a request on your behalf, we will verify the individual has your permission to receive the information and then we will share the information.

**What are some examples of when this might be used?**

- If an elderly parent wants an adult child to help understand treatment instructions
- If an adult child is helping with billing questions
- If a friend is helping and elderly patient with health issues
- If a college student wants information shared with a parent
- If an adult child calls to find out his/her parent's appointment time

**Can the person I designate also get copies of my medical records?**
No, they can only receive verbal information. To get copies of medical records, you must complete a separate Authorization form available at our office.

**What if I change My Mind?**
You must notify The Woman's Care Center in writing if you wish to revoke (stop) this process. The Woman's care Center is not responsible for information that has already been released in reliance upon a signed request form.

**What happens if I don't complete this form?**
We will continue to protect your private health information as required by law.

**Where do I send a written request for any changes?**
The Woman's Care Center
Release of Information
P O Box 669
Milledgeville, GA 31061

OR

Fax to 478-453-8186