The Woman's Care Center, PC
OB/GYN

Place patient sticker here

INSURANCE INFORMATION

DO YOU HAVE ONE OF THE FOLLOWING INSURANCES?

YES	NO	MEDICAID	YES	NO	MEDICARE
YES	NO	AMERIGROUP	YES	NO	CARESOURCE
YES	NO	PEACH STATE	YES	NO	WELLCARE
YES	NO	COMMERCIAL INSURANCE IF SO WHICH CARRIER			

_____

IT IS YOUR RESPONSIBILITY TO INFORM THE FRONT DESK OF ALL INSURANCES THAT YOU HAVE. PLEASE PRESENT YOUR INSURANCE CARD(S) TO THE RECEPTIONIST AT EACH VISIT.

IF YOU HAVE MEDICAID, AMERIGROUP, CARESOURCE, PEACH STATE, OR WELLCARE, AND ANY OTHER INSURANCE BOTH MUST BE GIVEN TO US AT EACH VISIT. THE INFORMATION YOU GIVE WILL NOT AFFECT YOUR MEDICAID COVERAGE. WE ARE REQUIRED TO FILE YOUR COMMERCIAL INSURANCE COMPANY FIRST AND MEDICAID PLAN SECOND.

IF YOU HAVE MORE THAN ONE COMMERCIAL INSURANCE PLEASE PRESENT ALL INSURANCE INFORMATION AT EACH VISIT. WE ARE REQUIRED TO FILE ALL INSURANCE THAT YOU HAVE IF WE ARE IN NETWORK WITH THEM. THE ONLY EXCEPTION IS IF YOU PREFER TO PAY CASH AND NOT FILE INSURANCE.

FAILURE TO REPORT ALL INSURANCE INFORMATION IS CONSIDERED **INSURANCE FRAUD** AND WILL RESULT IN YOU BEING RESPONSIBLE FOR YOUR CHARGES.

IF YOU HAVE ANY QUESTIONS, PLEASE ASK THE RECEPTIONIST.

PATIENT SIGNATURE_____ DATE_____

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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: _____

The Woman's Care Center, PC
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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 _____ Date_____

or Patient's Authorized Representative _____ Date_____

Relationship or Authority/Capacity to act on Patient's Behalf_____

Printed Name of Patient_____ Date of Birth_____

Home Phone: _____ Cell 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**_____

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 OR Fax to 478-453-8186
P O Box 669
Milledgeville, GA 31061

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights regarding my protected health information. I understand that this information can be and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physicians certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* form time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment for healthcare operations. I also understand you are not required to agree to my request restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name_____

Signature_____

Date_____