The Woman's Care Center, PC
OB/GYN

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		

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

PRIMARY CARE PHYSICIAN (PCP)	PCP PHONE NUMBER	REFERRED TO PRACTICE BY:

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PERMISSION TO VERBALLY DISCUSS PROTECTED HEALTH INFORMATION

Patient's Name: _____ *DOB:* _____ *Date:* _____

_____ **I DO NOT give permission to The Woman's Care Center to verbally discuss the following medical and billing information about me to anyone, unless notified in writing.**

_____ **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: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

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**_____

Policy as of 08/01/2023

The Woman's Care Center

Financial policy and Insurance Information

To accommodate the needs and requests of as many patients as possible The Woman's Care Center is contacted with numerous insurance companies. While we are pleased to be able to provide this service, it is not possible for our staff to keep track of all the individual requirements of each plan. Every plan has different stipulations regarding access to care and payment for services. Within the same insurance company, benefits may differ depending on upon what type of plan you are enrolled in.

1. I authorize the release of medical information to my primary care or referring physician and as necessary to process insurance claims, insurance applications, prior authorizations, pre-certifications, and prescriptions.
2. I am ultimately responsible for payment of charges for services I receive in your office. Any check payments dishonored by my bank will result in a $25.00 returned check charge added to my account.
3. It is my responsibility to provide the office with my current address, phone number and insurance information.
4. It is my responsibility to contact my insurance carrier to confirm the provider participate with my plan. If I see a doctor that is not currently on my plan, I will be responsible for the payment in full.
5. If I do not provide the correct coordination of benefits, I will be responsible for payment in full.
6. If my plan requires a referral, it is my responsibility to obtain this prior to being seen by my doctor.
7. Co-Payment, co-insurance and/or deductible payments are due at the time of service.
8. I understand any balance amount must be paid in addition to any co- pays, co- insurance, or deductible at time of service.
9. Laboratory services will be provided by a contacted lab company. Currently, we are contracted with Pro Path. Lab charges not covered by your insurance will be billed to you. We are unable to give you lab benefits or the estimated cost of lab services. I will be responsible for confirming with my insurance whether I am able to receive lab services through Pro Path.
10. If my account is referred to an outside collection agency this will result in my termination of medical care and will be subject to a collection fee of up to 35%. This will be added to the total balance at the time the account is turned over.

For questions and concerns regarding bills obtained from services by our providers please contact our billing company Vital Medical Billing at 706-413-8100.

Your signature below signifies your understanding and willingness to comply with these policies.

Signature _____ **Date** _____

Additional information can be found on our website at www.thewomanscarencenter.com.

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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* from 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.

Name: _____ Date: _____

Signature_____

Parent/Legal Guardian Name Authorized to sign: _____

NOTICE OF WRITTEN FINANCIAL POLICY AND FINANCIAL RESPONSIBILITY

I have received or reviewed a copy of the Written Financial Policy. I have fully read, understand, and given an opportunity to ask questions about the Financial Policy. I will cooperate with the above practice and the billing department of Vital Medical Billing to ensure payment for my services is received. I understand that I will be personally responsible for any cost(s) associated with my account that is not covered by insurance. I understand the terms of this financial policy may be amended at any time without prior notification to me, the patient. In the event that the patient is a minor, I am the parent and/or legal guardian of said patient and agree that I am responsible for payments for all services rendered to the patient.

Name: _____ Date: _____

Signature: _____

Parent/Legal Guardian Name Authorized to sign: _____

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Addition Office Information-Please read carefully

Appointment Times & Waiting

The Woman's Care Center, PC is a medical facility that treats both pregnant and non-pregnant women. Please understand that emergencies occur during the day that we are not able to control. This can include problems that arise at the office, or a provider needing to leave to go to the hospital. Sometimes these emergencies will require the help of additional providers and/or staff in the office. This can delay regular scheduled appointments, and we do our best to keep patients informed if their provider is running behind. Sometimes we are not always able to notify the patient before they arrive. Please understand that on any given day your wait time can vary anywhere from 30 mins to a couple of hours. Again, we do our best to see patients at their scheduled appointments, but are not always able to. If you are not able to wait to be seen, you are more than welcome to reschedule to another date. Please note, that arriving too early for your appointment, does not mean you will be seen sooner.

Multiple Providers

The Woman's Care Center, PC has three (3) Medical Doctors and two (2) Nurse Practitioners on staff. Certain providers are here on certain days and on any day, we have at least 3 providers in the office. Please understand that if you check in for your appointment and someone is called before you, it does not mean that we are skipping over you or you have been forgotten. Each provider has their own schedule and runs differently than others. If your provider is running behind, we will do our best to notify you of this. Again, if you are not able to wait to be seen, you are more than welcome to reschedule to another date.

Late/ No Show Policy

The Woman's Care Center, PC does not have a grace period for late appointments. If you are late, please note It is the provider's decision to work you back in the schedule or to ask you to reschedule. If you are going to be late, please call the office and let the front know that you are running behind and how long it will take, but it is still up to the provider. If the provider does allow you to be worked back in, you will be called back after all other appointments are worked up. This wait time can range from 30 mins to several hours. As stated before, we do our best to see patients at their scheduled times that arrive on time. If we ask you to reschedule, please understand that it is because our office can simply not accommodate you at that time. We can give you a note showing that you were here in the office and had to be rescheduled with new appointment date.

Thank you for being patient with our office and allow us to care for you or your family member!

I have read the following statements and I am aware of office information.

Name: _____ Date: _____

Signature: _____