The Woman's Care Center, PC

PATIENT INFORMATION				DATE
LAST NAME	FIRST NAME		MI	DATE OF BIRTH
SOCIAL SECURITY #	MARITAL STATUS (Please Circle One) SINGLE MARRIED DIVORCED WIDOWED			PREFERRED PHARMACY- WITH LOCATION
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:

The Woman's Care Center, PC

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	SELF PAY
YES	NO	COMMERCIAL			

IF SO WHICH CARRIER: _____

(This includes BCBS, UHC, Cigna, Aetna, MedCost, Humana, etc.)

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 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_____

The Woman's Care Center, PC

1. I _____ (patient name) give permission for **The Woman's Care Center** to give me medical treatment. I am asking for medical care and treatment at this facility and agree to accept services which may diagnose a medical condition, procedures to treat my condition and routine medical care. I have not been given any guarantees as to the results of the services I will receive.

2. I allow **The Woman's Care Center** to file for insurance benefits to pay for the care I receive.

   I understand that:
   - **The Woman's Care Center** will have to send my medical record information to my insurance company.
   - I must pay my share of the costs.
   - I must pay for the cost of these services if my insurance does not pay or I do not have insurance.

3. I understand:
   - I have the right to refuse any procedure or treatment.
   - I have the right to discuss all medical treatments with my clinician.
   - That my agreement to accept these services will remain in effect unless I say that I no longer want these services or until my treatment is completed.
   - That my agreement to accept these services is called a General Consent and that it includes any routine procedure(s) or treatment(s) such as blood drawing, physical examination, urine screenings, and other non-invasive procedures.

_____ _____

Patient's Signature Date

_____ _____

Parent or Guardian Signature (for children under 18) Date

_____ _____

Print name

The Woman's Care Center, PC

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:

******This does not include other medical facilities, this is for family or friends only*******

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**_____

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 478-453-4475
P O Box 669
Milledgeville, GA 31061

The Woman's Care Center, PC

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

A copy to keep is available upon request

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

A copy to keep is available upon request

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: _____

The Woman's Care Center, PC

Addition Office Information-Please read carefully

Appointment Times & Waiting

The Woman's Care Center, PC is a medical facility that treats 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 two providers, (1) Medical Doctor and one (1) Nurse Practitioner on staff. Certain providers are here on certain days. 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. There is a $25 No Show Fee for any appointment not cancelled within 24 hours of your appointment. That fee must be paid before any future appointments can be made

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: _____