Austin Springs Women's Health

DEMOGRAPHICS: Marital Status: Married ◯ Single ◯ Separated ◯ Divorced ◯ Widow ◯

Patient Name: _____ Date of Birth: _____/_____/_____ Sex: _____

Phone #: (_____) _____-_____ Ethnicity: _____ Race: _____

Email: _____ **Primary Care Provider**: _____

Mailing Address: _____ **Zip code:** _____ **Pharmacy #:**_____

INSURANCE INFORMATION: (Input primary insurance first, then secondary)

Insurance Name: _____ **Subscriber ID:** _____ **Group:** _____

Policy Holder: _____ **Date of Birth:** _____ **Relationship:** _____

Claims Address: PO BOX: _____ **City:** _____ **State:** _____ **Zip:** _____

EMERGENCY CONTACT:

Name:_____Phone #_____

Relationship:_____ Is it ok to leave a detailed message? YES ☐ NO ☐

HIPAA-ACKNOWLEDGEMENT OF RECEIPT- PRIVACY NOTICE

Due to the Health Insurance Portability and Accountability Act (HIPAA) of 1996, the following information must be completed and updated annually by each patient. Please log onto: www.austinwomenshealthcare.com for a copy of the Notice of Privacy Practice.

I have been given the opportunity to read and receive a copy of Austin Springs Notice of Privacy Policy. I understand that Austin Springs Women's Health will only use and/or disclose PHI (protected health information) for treatment, payment, or healthcare operations. _____ initial

This release authorizes Austin Springs Women's Health and its providers to discuss medical information regarding my care, billing, medical condition, treatment, or diagnosis with the following:

Myself only **Spouse** _____ **Parent**_____ **Other:** _____

Phone: _____ **Phone:** _____ **Phone:** _____

ASSIGNMENT OF BENEFITS

With this form I acknowledge that I have been provided a copy of the Notice of Privacy Practices of Austin Springs Women's Health. I authorize the release and disclosure of portions of my medical record necessary for myself. This authorization gives Austin Springs the right to request and receive medical information from other health card entities and provider to include, but not limited to, copies of lab results, diagnostic test reports, films/images, ad other clinical information deemed necessary by Austin Springs Women's Health, its physicians, and representatives. I may inspect my protected health information, request more information, and revoke this authorization, as permitted by the Federal Privacy Regulation and in accordance with Austin Springs Women's Health Privacy Policy. _____ **initial**

RELEASE OF BILLING INFORMATION

I authorize the above-named practice to release any information acquired during my treatment to my insurance company, employer, physicians, institutions, or third-party payers, as required for certain claims filed.
I understand that, even though I may have some type of insurance and authorize this office to submit charges on behalf of myself. I am also responsible for payment such as copays, deductibles, coinsurance and in and out of network charges. I hereby assign to the doctor, all payments for medical services rendered. I am aware that copayment is required each visit, and if there is no insurance coverage, payment in full is required for services provided unless prior payment arrangements have been discussed. I will also be responsible for all collection fees, should my account be assigned to a Collection Agency, MSB_____initial

Austin Springs Women's Health

CONSENT TO CALL

By initialing below, I give permission for Austin Springs Women's Health to use the information provided as park of the check in process to email, send patient portal message and call the patient. This includes: Entry of any telephone contact number constitutes written consent to receive any automated, prerecording, and artificial voice telephone calls initiated by the Practice. To alter or revoke the consent, visit the Patient Portal "Contact Preference". _____ **initial**

In the event you have not registered for your patient portal, may we leave a detailed message of any normal lab, imaging or medical information regarding your medical condition or treatment. (Please refer to our Lab Results Policy at our office).

Phone Number: _____ **Personal Cell** ☐ **Home** ☐ **Work** ☐

In the event a family member or caregiver attends my office visits and is in the exam room at the time of my evaluation and/or treatment, I give Austin Springs Women's Health and its provider's permission to discuss freely my condition, treatment, or diagnosis with that person: **YES** ☐ **NO** ☐

Prescription Medication Policy & Agreement

The following is an outline of our prescription medication refill policy for Austin Springs Women's Health providers.

Name of Pharmacy: _____ **Phone Number:** _____

- If you need a refill on your medication(s), please, call your pharmacy first. The pharmacy will then fax or call us with all the information we need to be able to refill.
- **Please be aware that we cannot refill medications after business hours or on weekends**. Please make sure that you contact your pharmacy at least **7 days** before you run out of medication. That should allow enough time for the refill to be processed. If you are on your last refill, YOU MUST MAKE AN APPOINTMENT FOR A FOLLOW UP/PRESCRIPTION REFILL OR WELL WOMAN EXAM.
- **Narcotic medication: You will need to come in for an appointment.**

In case of an emergency, life threatening situation or concerning symptoms, CALL 911, or proceed to the nearest emergency room. I have read, understand, and agree to the above prescription medication policy.

Signature: _____ Date: _____

Medication Authority: We are implementing a new Electronic Medical Records program that will automatically import your medication history from third party sources (i.e. Pharmacies) In order to transfer you current and past medications to the new system we must have your authority. By initialing you are allowing us to transfer your medication history to your personal chart with Austin Springs Women's Health and its providers _____ (initial)

Lab Services: Our office utilizes **Pathgroup Laboratories** (separate entity), which accepts most insurance, if you desire to utilize a different laboratory, please notify our front desk. You will be billed separately for you blood work, pathology, and cultures. You may contact their billing department for any billing inquiries: 888-474-5227

Austin Springs Women's Health

Patient Policies

Austin Springs Women's Health and its providers places a high priority on customer service. We are available to answer your non-emergency calls, from 8:00 AM to 4:30 PM, Monday through Thursday. **After hours what do you do? Call: 512-660-6301.** For emergency situations, dial 9-1-1 or go to the nearest Emergency Room.

Financial Policy

All payments are due at the time of service. This included copayments, deductible, and past due balances. It is YOUR responsibility to inform us of any changes with your insurance and to determine if your insurance is IN-NETWORK or OUT-OF-NETWORK. Many insurances have "timely filing deadlines". If we are not provided with accurate information at the time of service, you may be responsible for payment in full for all services rendered. Please keep in mind that your insurance is a CONTRACT between you and the insurance company. Not all insurance cover all procedures. While we make good faith to verify coverage, we are not able to guarantee that the information given to us by your or the insurance company are correct. It is your responsibility to know what services may or may not be covered by your insurance.

Uninsured Patients

Patients without insurance will be offered a Prompt Pay Discount ONLY if balance due is paid in full. If balance can not be paid in full at the time of service, a payment plan will be established, and your will be assessed the full amount due without any discounts.

Payments

All payments are due at the time of service unless prior arrangements are made. We accept Debit and Credit Cards only. No cash or checks accepted. Any outstanding balances, including deductibles, are due within 30 days of the statement. If payment is not received within 45 days, an administrative fee of $25 will be assessed on the account. All balance reaching 90 days past due will be sent to our collection agency "MSB". If you experience circumstances beyond your control, please contact our billing office and we will be more than happy to make arrangement. ALL statements and/or outstanding balances are available via your patient portal. A courtesy paper statement will be sent when requested.

Convenient AutoPay

Retain your credit card on file in a safe encrypted environment. This feature is available to ensure all our payments are received on time and helps you avoid administrative fees if paid after 45 days. By enrolling in Convenient Auto-Payment, we can use it to collect copayments and bill your insurance first and notify you via email 5 days before your credit card is charge for balances due.

Third Party Payers

Our office does not bill third party payers (TPA) such as, PIP (Personal Injury Protection) for a motor vehicle accident or attorneys.

Returned Checks

Checks returned to us by the bank will assess a returned check fee of $75 in addition to the original amount of the check.

Missed Appointments

We understand there will be times when a scheduled appointment cannot be kept. If you need to cancel or reschedule an appointment, we request that you notify our office 24 hours in advanced to avoid a **$50 cancellation fee**. Ultrasound appointments: **$75 cancellation fee**. Surgery/Procedure Appointment: **$150 cancellation fee.** If your appointment is made for "same day" and you find yourself unable to keep it, please call to cancel within a minimum of three hours-notice in orders for another patient to be scheduled. If you do not call or show up for your appointment, we will consider this a "no call no show". If this happens 3 times, then the office may terminate the doctor-patient relationship.

Late Policy

We are committed to prompt service, and will work extremely hard, barring emergencies, to stay on time. We may ask you to reschedule if you arrive for your appointment more than 15 minutes after your scheduled appointment.

Termination of Doctor-Patient Relationship

Our office values its patient relationship and want to protect patient's right. We will terminate the patient relationship with cause and after careful consideration. Reasons for termination include repeatedly not showing up to scheduled appointments, not complying with recommended medical card, requesting medical records to another OBGYN, being hostile or abusive to staff, not paying past due balances within 6 months of statement.

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Patient Policies Continuation

After Hours Services

If you need medical assistance after 4:30 pm Monday-Thursday or after 2 pm on Fridays or on the weekend, we provide after hour virtual call services. This is a nominal fee of $75 and will be billed as self-pay.

If you have an emergency, such as chest pain, severe shortness of breath, severe headache, or bleeding, call 911 or proceed directly to the nearest hospital emergency room. You can always call the office with any questions about acute medical problems after hours. If the physician is not in the office, please call our **On Call Service: 512-660-6301.**

Medical Record Release and & Form Fees

We will provide copies of your medical records within 15 business days of signed record release and the nominal charge. Provider to Provider Records release; there is **no charge**. For patients to obtain medical records, there is a **$25 fee,** FMLA/Disability paperwork: **$25 fee** will be collected prior to faxing or releasing paperwork (Please allow 5-7 business day for completion. **All outstanding balances MUST be paid in full prior to transferring medical records.**

By checking the box, you consent for the credit card on file to be run the same day of transfer of medical records and or FMLA/Disability forms.

Insurance Card/Identification Card

A current insurance card is required at every appointment and a valid ID (not expired) is vital in ensuring that services are billed correctly. If a patient does not have a current copy of her insurance card, she has the option of paying in full for that day. Once received, we will bill the insurance and refund self-pay amount once claim is paid by your insurance company.

HMO Plan/Prior Authorization

It is the patient responsibility to know their benefits. Please contact member service number on the back of the insurance card. Your insurance representative will go into detail with your benefits and inform you of your patient responsibility. It is the patient's responsibility to retrieve a referral from their primary care provider prior to your appointment with your provider. If a referral is not present and your claim is denied. You will be responsible for all denied claims. Please call prior to your visit.

Consent for Treatment

I hereby voluntarily consent for treatment. I permit Austin Springs Women's Health and its providers, employees, medical staff, and others involved in my care to treat me in ways they judge to be beneficial to me. I understand that I have the right to ask questions and to receive information about my care and treatment, and the right to **withdraw my consent for treatment or tests.**

I consent to examinations, blood tests (including blood tests for communicable diseases such as hepatitis and HIV/AIDS when healthcare personnel have been exposed to my blood and/or body fluids), laboratory and imaging procedures, medications, infusions, nursing care and other services or treatments rendered by my physician.

I am aware that the practice of medicine is not an exact science and further understand that no guarantee has been or can be made as to the results of the treatments, care, or examinations in the facility.

The undersigned certifies that he/she has read the foregoing, understands it, accepts its terms, has received a copy of it and is the patient or is duly authorized by the patient as their agent executes the above. _____**(initial)**

Telehealth Consent

I consent to treatment involve the use of electronic communication to enable health care providers at different location to share my individual patient medical information for diagnosis, therapy, follow up, and/or education purposes. I consent to forward my information to a third party as needed to receive my telemedicine services, and I understand that existing confidentiality protections apply. I acknowledge that while telemedicine can be used to provide improved access to medical care, as with any medical care, as with any medical procedure, there are potential risks, and no results can be guaranteed or assured. These risks include but are not limited to technical problem with information transmission; equipment failures that could result in lost in information or delays in treatment. I understand that I have a right to withhold or withdraw my consent to the use of telemedicine during my care at any time.

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Nurse Practitioner Consent for Treatment

This facility has on staff a Nurse Practitioner to assist in delivery of medical care. Nurse Practitioners are not doctoring. A Nurse Practitioner is a Registered Nurse licensed under the Board of Nursing, who has received advanced education and training in the provision of health care. Under the supervision of a physician, a Nurse Practitioner can diagnose, treat, and monitor common acute and chronic disease as well as provide health maintenance care. "Supervision" does not require the constant physical presence of the supervising physician, but rather overseeing the activities of and accepting responsibility for the medical services provided. These services may include but not limited to: obtaining histories and performing physical exam, ordering and/or performing diagnostics and therapeutic procedures, formulating a working diagnosis, developing and implementing treatment plan, monitoring the effectiveness of therapeutic inventions, offering counseling and education, supplying sample medications and writing prescriptions, making appropriate referrals, providing prenatal care and women's health, and performing office procedures (i.e. Nexplanon insertion, IUD placement and removal, colposcopy, EMB, skin biopsies).

Credit Card on File Policy

Maximum Charge in 365 days: $3000

This is not a receipt. This is an agreement agreeing to pay for services once patient liability has been determined. The terms of this agreements are outlined below.

Agreement Terms:
Effective Date: Your first day of scheduled appointment
Expiration Date: One year

I agree to allow the practice to charge my card during the effective period for the balance due, as determined by the final adjudication of all claims including under this contract. I agree to the final adjudication amount as defined by my insurance company, with exception as noted below. I agree to these charges under the following conditions:

- The amount charged to my card will not exceed the agreed-upon maximum dollar amount.
- My credit card will be stored by Elavon, Inc., a secure credit card processor affiliated within U.S. Bank that partners with the practice to collect payments.
- I will receive a bill from the practice via patient portal for any balances greater than the maximum dollar for which I am liable once the transaction has been executed.
- I may cancel this agreement at any time by contact the practice.

We have implemented a policy requiring a credit card held on file effective 01/01/2020. As you may be aware, the current healthcare market has resulted in insurance policies increasingly transferring cost to you, the insured. Some insurance plans required deductible and copayment in amounts not known to you or us at the time of your visit. Like hotels and car rental agencies, you are asked for a credit card number at the time you check in and the information will be securely until your insurance has paid their portion and notified us of the amount of your share, you will receive a statement. At that time, any remaining balance owed by you will be charged to your credit card, and a copy of the charge will be mailed to you. This is an advantage since it makes checkout easier, faster, and more efficient. This in no way will compromise your ability to dispute a charge or question your insurance company's determination of the payment. Patients with verified ACTIVE Medicaid coverage are exempt from having a card on file. If you have any questions about this payment method, do not hesitate to ask.

By signing below, you have read entirely and fully understand and accept patient's responsibility and office policies and protocols.

Patient Name: _____ Date: _____

Patient Signature: _____ Appointment Date: _____