Date: _____

Dr. _____

BAY AREA PHYSICIANS for WOMEN

New Patient Information Sheet

Please fill out all information. (PLEASE PRINT)

Patient Information

Last Name: _____ **First Name:** _____ **Middle Name:** _____

Preferred Name: _____ **Marital Status:** _____ **Maiden Name:** _____

D.O.B. ____/_____/_____ **Age:** _____ **Sex:**_____ **SSN #** _____-_____-_____

Race: (circle one) Asian Black Hispanic American Indian Native Hawaiian White

Primary Language: (circle one) English Spanish Other

Ethnicity: (circle one) Hispanic or Latino Not Hispanic or Latino

Pharmacy Information

Preferred Pharmacy Name: _____ **Phone #:**_____

Address: _____ **City/State/Zip:** _____

Address Information

Address: _____ **City/State/Zip:**_____

Contact Information

Cell Phone: _____ **Home Phone:** _____ **Work Phone:** _____

Email: _____ **Patient's or Parent's Employer:** _____

Preferred Method of Appointment Reminder (circle one) **Text Message** **Email**

Emergency Contact **Relationship** **Phone #**

_____ _____ _____

I give permission to Bay Area Physicians for Women, P.C. to administer treatment and perform necessary minor operative procedures in diagnosing and treating my condition. By signing this form, I am granting consent to Bay Area Physicians for Women, P.C. to use and disclose protected health information (PHI) for the purposes of treatment, payment, and health care operations. You have a legal right to review our Notice of Privacy Practices before you sign this consent and we encourage you to read it in full. You have the right to request us to restrict how we use and disclose your PHI. We are not required by law to grant your request, but if we do, we are bound by our agreement. You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your PHI in reliance of your consent.

Signature: _____ **Date:** _____

BAY AREA PHYSICIANS for WOMEN

PAYMENT OF CHARGES/ASSIGNMENT OF INSURANCE

All professional services rendered are charged to the patient. Necessary forms will be completed to expedite insurance carrier's payments. The patient is responsible for all fees, regardless of insurance coverage. All copays are due at the time of service. It is customary to pay for services when rendered unless other arrangements have been made in advance. Failure to make payment when requested is basis for legal action and the undersigned agrees to accept the fee charged as a legal and lawful debt and agrees to pay said fee, including any/all collection agency fees(33.3%), attorney fees and /or court costs, if such be necessary. I waive now and forever my right to exemption of the above under laws of the constitution of the State of Alabama and any other state. I (we) the undersigned, hereby state that I (we) have read and thoroughly understand the above declaration.

CARD ON FILE

I, undersigned, give Bay Area Physicians for Women the right to charge my card on file for any bill $20.00 or less automatically.

INSURANCE AUTHORIZATION

I hereby assign to Bay Area Physicians for Women all payments for medical treatment.

PBM CONSENT

Consent is given from the patient to the prescriber to obtain the patients' medical history if it is available.

CONSENT TO CONTACT BY CELLPHONE

I, undersigned, give Bay Area Physicians for Women, its employees and/or agents "express prior consent" to contact me at any/all phone numbers, including cell phone numbers (by phone call or text message), which may result in a charge to me, or by sending emails using any email address I have provided to use, for the purpose of treatment, insurance, or payment. Methods of contact may include using pre-recorded/artificial voice messages and /or use of automatic dialing device, as applicable.

NOTICE OF PRIVACY PRACTICES and NOTICE OF INDIVIDUAL RIGHTS

I acknowledge by signing below that the Notice of Privacy Practices and Notice of Individual Rights has been made available to me.

CANCELATION AND NO SHOW POLICY

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you would like to cancel your appointment, you **provide 24 hour notice**. Patients who do not arrive for their appointment without notifying us will be considered a NO SHOW. Patients who NO SHOW two (2) or more times in a 12 month period, may be dismissed from the practice and thus be denied future follow up appointments with Bay Area Physicians. Patients may also be subject to a $30.00 fee for an office appointment No Show. The cancellation and No Show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment. We understand that special circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with Management approval.

I acknowledge by signing below that I have received the Notice of Privacy Practices and Notice of Individual Rights located on the reverse side.

_____ _____/_____/_____

Patient Name (Please Print) **Date of Birth**

_____ _____ _____/_____/_____

Signature of Patient or Responsible Party **Relationship** **Date**

1/31/2022

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU. The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures, we will elaborate on the meaning and provide more specific examples, if you request. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories. We must obtain your authorization before the use and disclosure of any psychotherapy notes, uses and disclosures of PHI for marketing purposes, and disclosure that constitute a sale of PHI. Uses and disclosures not described in this Notice of Privacy Practices will be made only with authorization from the individual.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive at the Practice may be billed to and payment may be collected from you, an insurance company or a third party. For example: we may disclose your record to an insurance company, so that we can get paid for treating you.

For Treatment. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you at the Practice or the hospital. For example, we may disclose medical information about you to people outside the Practice who may be involved in your medical care, such as family members, clergy or other persons that are part of your care.

For Health Care Operations. We may use and disclose medical information about you for health care operations. These uses and disclosures are necessary to run the Practice and ensure that all of our patients receive quality care. We may also disclose information to doctors, nurses, technicians, medical students, and other Practice personnel for review and learning purposes. For example, we may review your record to assist our quality improvement efforts. WHO WILL FOLLOW THIS NOTICE. This notice describes our Practice's policies and procedures and that of any health care professional authorized to enter information into your medical chart, any member of a volunteer group which we allow to help you, as well as all employees, staff and other Practice personnel.

POLICY REGARDING THE PROTECTION OF PERSONAL INFORMATION. We create a record of the care and services you receive at the Practice. We need this record in order to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the Practice, whether made by Practice personnel or by your personal doctor. The law requires us to: make sure that medical information that identifies you is kept private; give you this notice of our legal duties and privacy practices with respect to medical information about you; and to follow the terms of the notice that is currently in effect. Other ways we may use or disclose your protected healthcare information include: appointment reminders; as required by law; for health-related benefits and services; to individuals involved in your care or payment for your care; research; to avert a serious threat to health or safety; and for treatment alternatives. Other uses and disclosures of your personal information could include disclosure to, or for: coroners, medical examiners and funeral directors; health oversight activities; law enforcement; lawsuits and disputes; military and veterans; national security and intelligence activities; organ and tissue donation; public health risks; and worker's compensation.

NOTICE OF INDIVIDUAL RIGHTS

You have the following rights regarding medical information we maintain about you:

Right to a Paper Copy of this Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. We may deny *your* request to inspect and copy in certain very limited circumstances.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by, or for, the Practice. To request an amendment, your request must be made in writing and submitted to the Privacy Officer and you must provide a reason that supports your request. We may deny your request for an amendment.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. ***We are not required to agree to your request.*** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to the Privacy Officer.

Right to Request Removal from Fundraising Communications. You have the right to opt out of receiving fundraising communications from the Practice.

Right to Restrict Disclosures to Health Plan. You have the right to restrict disclosures of PHI to a health plan if the disclosure is for payment of health care operations and pertains to a health care item or service for which the individual has paid out of pocket in full.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You must make your request in writing and you must specify how or where you wish to be contacted.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer. CHANGES TO THIS NOTICE. We reserve the right to change this notice. We will post a copy of the current notice in the Practice's waiting room. COMPLAINTS. If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice, contact Grace Cotney, Privacy Officer, 251-344-5900 at 3715 Dauphin St. Ste 3B, Mobile AL 36608 All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

OTHER USES OF MEDICAL INFORMATION. Other uses and disclosures of medical information not covered by this notice or the laws that apply to use will be made only with your written authorization. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time.

If you have any questions about this notice or would like to receive a more detailed explanation, please contact our Privacy Officer.

I acknowledge by signing below that I have received the Notice of Privacy Practices and Notice of Individual Rights.

_____ _____

Patient or Patient's Personal Representative **Date**

BAY AREA PHYSICIANS FOR WOMEN, P.C.

ALTERNATIVE CONTACTS COMMUNICATION AUTHORIZATION FORM

When it comes to your treatment, we strive to communicate with you in a timely and professional manner. There are certain occasions when family members, friends, or others might be involved in your care as a patient and you will want our office to be able to communicate directly with them. In order to protect the privacy of your personal health information, please share with us the names of any other people with whom we can discuss your care and share your protected health information.

PLEASE PRINT

Patient Name_____ **Date of Birth**_____

I AUTHORIZE BAY AREA PHYSICIANS FOR WOMEN TO DISCUSS MY MEDICAL INFORMATION WITH THE FOLLOWING:

NAME:_____ RELATION_____

NAME:_____ RELATION_____

NAME:_____ RELATION_____

I UNDERSTAND IF NO ONE IS DESIGNATED ABOVE THEN MY MEDICAL INFORMATION WILL BE KEPT CONFIDENTIAL AND CAN ONLY BE DISCUSSED WITH ME, THE PATIENT. I ALSO UNDERSTAND THIS AUTHORIZATION WILL STAY IN FULL FORCE UNTIL A REVISED FORM IS COMPLETED AND SIGNED WITH BAY AREA PHYSICIANS FOR WOMEN.

_____ _____

signature date

Witnessed by Bay Area Physicians for Women Employee

_____ _____

signature date