Dr. Larry F. Overcash, M.D., F.A.C.O.G.
Erin J. Overcash, W.H.N.P.

Women's Health INSTITUTE

PATIENT INFORMATION

Patient Name_____ Age_____ Sex_____

Birthdate____/____/____ Single ____ Married ____ Widowed ____ Divorced ____

Race _____ Ethnicity _____ Language _____

Address_____

City _____ State _____ Zip _____

Home Phone (____)_____ SS# _____

Cell Phone (____)_____ Emergency Phone (____)_____

Work Phone (____)_____Email _____

Spouse or Parent Name _____ Birthdate ____/____/____

Spouse/Parent Phone (____)_____

Referring Doctor _____ Family Physician _____

FINANCIAL & HIPAA POLICY

It is our hope that you will understand that our financial and billing policies are necessary to maintain vital health care policies, which may be changed at any time without notice.

Insurance
We will bill all primary insurance companies and any secondary insurance for our patients. Please provide us with complete and accurate insurance information, as well as any changes of address, telephone number or employer. At your request, we will send you documentation that will enable you to contest what your insurance company will not pay based on usual and customary allowance.

PPO/HMO
Although we strive to be members of as many networks as possible, there are exceptions; check with your insurance prior to seeing a physician regarding network status. Patients will be billed for any out of network fees. Women's Health Institute accepts Medicare assignment. If your insurance plan is an HMO you may be required to obtain a referral/authorization from your primary care physician prior to an office visit. Patients wanting to see a physician without an HMO referral will be required to sign a waiver assuming responsibility for payment.

Co-Payments
Co-payments will be collected on the day of your appointment. All insurance companies require that the physician collect all co-pays from the patient. It is the patient's responsibility to know his/her insurance benefits. Any disputes regarding co-pays and deductibles must be settled between the patient and your insurance.

Refund
Patient refunds are issued monthly. Refunds will not be issued until all pending claims are settled with insurance.

Private Supplement Policy
A $25.00 service fee will be charged to the patient for information requested for insurance policies for which the patient is solely reimbursed, for example cancer or disability policies.

Statements
Itemized statements are issued monthly. (through mail or patient portal, whichever you have signed up for) Messages on the statements will indicate the status of your account. Payment is expected within thirty days of first statement. Collection process will begin at thirty-one days.

Ancillary Services
Technical fees for x-ray, lab and sonography will be billed by Women's Health Institute. Fees for radiologist, pathologist or facility may be billed by an outside provider.
Our office has no association regarding network status of these vendors.

No Show Fee
If a patient fails to show up for an appointment or arrives later than 15 minutes to the appointment, a **$25 no show fee** will be charged that is not covered by insurance.

Authorization to Release Information
Permission is hereby given to Women's Health Institute to release medical information requested by my insurance company or by another doctor. I request that payment of insurance benefits be made directly to Women's Health Institute.
I understand coverage is a contract between me and my insurance company and I agree to accept financial responsibility for payment of charges incurred.
I also understand I am responsible for any costs of collection (if necessary) such as collection fees at 25% of unpaid balance, attorney fees and court costs.
By signing below, you are authorizing us or any agency working on our behalf to call you at any number you provide including calls to mobile/cellular or similar devices for any lawful purpose. You agree to any fees or charges that you may incur for the incoming calls from us, and / or outgoing calls to us, to or from any such number, without reimbursement from us.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT
I understand that, under the Health Insurance Portability & Accountability Act of 1996 (**"HIPAA"**), I have certain rights to privacy regarding my protected health information. I understand that this information can 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 physician 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 above to obtain a current copy of the *Notice of Private 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 or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do not agree then you are bound to abide by such restrictions.

LABS
Labs will be sent to LabCorp unless patient requests otherwise. It is the responsibility of the patient to call for lab results. Our staff will call for any abnormal lab findings.

Medication History
Patient grants access to share information with physician and pharmacy pertaining to medication history.
I have read, received and understand this financial and HIPAA policy.

Patient Name_____ DOB____/____/_____
(Please print)
Signature_____Date_____
(Parent or guardian if patient is a minor)
Please Check Box if Health Information can be given to a family member ☐

Information released to: _____