WOMEN'S HEALTH AND WELLNESS

Patient: _____ Date of Birth: _____ Age: _____

Address: _____ SS#: _____

Cell: _____ Email: _____ Marital Status: _____

Consent to text: yes or no (appointment reminders, messages to contact the office)

Employer: _____ Primary Care Provider: _____

Emergency Contact Name/Number: _____ Relationship: _____

Referred By: _____

Pharmacy Name/Address/Number: _____

Optional:

Race: _____ Ethnicity: _____

Billing Requirements

Policy Holder

Relationship to Patient: **Self** **Spouse** **Parent** **Sex: Male** **Female**

Name: _____ DOB: _____ SS#: _____

Address: _____ Cell: _____

Insurance Information

Primary and #: _____ Policy #: _____ Group: _____

Secondary and #: _____ Policy #: _____ Group: _____

Appointment Policy

I am aware that the office has a last minute cancellation/no show policy in place. There is a $35 charge for less than 24 hours notice. The fee may be waived in certain circumstances. If the office is not open, we have a 24 hour answering service, that is available for messages to be left.

Signature: _____
Date:_____

Women's Health and Wellness

In our efforts to comply with the Health Information Portability and Accountability Act (HIPAA), we need to be certain that we guard your privacy according to your wishes when it comes to family, friends and co-workers.

PLEASE CIRCLE YOUR RESPONSE TO THE FOLLOWING:

May we leave messages concerning your **appointments** with a co-worker, receptionist, or secretary that regularly answers your calls?

Yes No N/A

May we leave messages on your voicemail at work?

Yes No N/A

May we leave a detailed message on your CELL/HOME voicemail?

Yes No N/A

Please list any people we are allowed to discuss appointments/treatments with and their relationship to you:

Name	Relationship	Phone #
Name	Relationship	Phone #
Name	Relationship	Phone #
Name	Relationship	Phone #

You must inform us, in writing, of any changes in your directives. This record needs to be updated annually.

Signature	Date Signed
Printed Name	Date of Birth

FINANCIAL RESPONSIBILITY AGREEMENT

Patient Name: _____ DOB: _____

I understand and agree that I will be financial responsible for any and all charges for services not paid by insurance for my visits. This includes any medical services, office visits, wellness exams, lab testing and any diagnostic testing ordered by the physician or staff.

I understand and agree it is my responsibility and not the responsibility of the physician or clinic to know if my insurance will pay for my medical service, office visit, wellness exam, lab testing or any diagnostic services ordered by the physician or staff.

I understand and agree that it is my responsibility to know if my insurance has any deductible, copay, or co-insurance, out of network amount, usual and customary limit, or any type of benefit limitation for the service I receive, and agree to make full payment.

I understand and agree it is my responsibility to know if the physician or provider I am seeing is contracted as an in-network provider recognized by my insurance company or specific plan. If the physician is not recognized by my insurance company or plan, it may result in claims being denied or higher out of pocket expense to me. I understand this and agree to be financially responsible and make full payment.

I understand and agree that it is my responsibility to know if my insurance company requires any referrals or authorizations. I understand it is my responsibility to make sure all required information has been submitted prior to any appointments. If any charges have been denied, I understand that I will be billed and payment will be due in full.

Patient Name: _____ Date: _____

Patient Signature: _____

Guarantor Name (if patient is minor only): _____

Guarantor Signature: _____ Date: _____

DISCLOSURES AND CONSENTS

Patient Name: _____ Date of Birth: _____

ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize direct payment of my insurance benefits to Women's Health and Wellness for services rendered to my dependents or me by the physician or under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services are a covered benefit. I understand and agree that I will be responsible for any co-pay, deductible, coinsurance or balance due that we were unable to collect from my insurance carrier for whatever reason.

MEDICARE/MEDICAID/CHAMPUS INSURANCE BENEFITS:

I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my or my dependents records that these programs may request. I hereby direct that payment of my or my dependents authorized benefits be made directly to Women's Health and Wellness.

AUTHORIZATION TO RELEASE NON PUBLIC PERSONAL INFORMATION:

I hereby authorize Women's Health and Wellness or the physician individually to release any of my or my dependents medical or non-incidental non-public personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

AUTHORIZATION TO MAIL, CALL, OR E-MAIL:

I certify and understand the privacy risks of mail, phone calls and e-mail. I hereby authorize a representative of my physician to mail, call or e-mail me with any communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying our office.

LAB AND DIAGNOSTIC SERVICES:

I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pay, deductible, or co-insurance if they are not reimbursed by my insurance for whatever reason.

CONSENT TO TREATMENT:

I hereby consent to evaluation, testing and treatment.

Patient Signature: _____ Date: _____