Send Completed form to:

Fax: (210) 922-6553

Phone: (210) 922-3331

Email: info@paloaltowomenshealthcenter.com

You may bring the completed forms to your appointment

PATIENT INFORMATION

Patient's Name (First Middle Last) _____

Date of Birth: _____ SSN _____ Marital Status: □ Single □ Married □Other_____

Address: _____City: _____State: ____ Zip: ____

Home Phone: _____ Cell Phone: _____Email: _____work phone_____

Preferred Language: □ English □ Spanish □ Other _____

Race: □ Asian □ African American □ American Indian/Alaskan □ White □ Other _____

Ethnicity: □ Hispanic/Latino □ Not Hispanic/Latino □ Other _____

Preferred Contact Method: □ Cell Phone □ Mail □ Patient Portal □ E-mail□ Home Phone□ Work Phone

Preferred Reminder Method: □ Cell Phone □ Home Phone □ Work Phone □ Mail □ Patient Portal □E-mail Text

Primary Care /Referring Physician: _____ Telephone #:_____

Employment status: □Employed □Self-employed □Retired □Other

Employer/School Name: _____

Employer Address: _____ City: _____State: _____Zip: _____

Preferred Pharmacy_____ Location: _____Phone#_____

In Case of emergency _____Relationship _____ Phone: _____

INSURANCE INFORMATION

□Medicaid Pending □ Private Pay

Primary Insurance Name: _____ Policy ID#: _____Group# _____

Insurance Holder: _____ DOB: _____ SSN: _____Relation: _____

Secondary Insurance Name: _____Policy ID#: _____Group#_____

Insurance Holder: _____DOB: _____ SSN: _____relation_____

If your plan is HMO you need referral from you primary care physician.

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CONSENT TO TREAT AND RELEASES

Consent to Treat

I (or my legal guardian or parent), authorize PAWHC to provide medical care as deemed necessary.

Signature Patient/Parent/Legal Guardian _____Date_____

Consent to Release

I authorize Palo Alto Women's Health Center (PAWHC) to release any and all information necessary concerning my diagnosis and treatment for the purpose of securing payment from my insurance company.

Signature Patient/Parent/Legal Guardian_____Date_____

Signature Patient/Parent/Legal Guardian_____Date_____

Assignment of Benefits

I hereby assign to (PAWHC) any insurance or other third-party benefits available for health care services provided to me. I understand that PAWHC has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to PAWHC, I agree to forward to PAWHC all health insurance and other third-party payments that I receive for services rendered to me, immediately upon receipt. I understand that I am financially responsible for all charges whether or not they are covered by insurance. Signature Patient/Parent/Legal Guardian_____Date_____

Medicare Beneficiary Assignment and Release

I request payment of authorized Medicare benefits to me or on my behalf for any services furnished me by PAWHC. I authorize any holder of medical or other information about me to release to Medicare and its agents any information required to process this claim to my employer, prospective employer and/or insurance carrier.

Signature Patient/Parent/Legal Guardian_____Date_____

Palo Alto Women's Health Center Patient Financial Policy

Clear understanding of this policy as well as your payment of services provided is an important part our professional relationship with you. Please ask if you have questions about our policy.

We look forward in building a lasting professional relationship with you.

All new patients must complete our patient information and present an official photo ID and Insurance card before seeing the doctor.

Your insurance card must be presented at each visit.

If you have any change of address, telephone number(s), employer, or insurance, please provide us with the correct information. It is your responsibility to notify us of such changes.

PAYMENTS

All co-payments, deductible, co-insurance and past due balances are due at check-in and before surgical procedure unless previous arrangements have been made with our billing coordinator/check-in staff.

We accept cash, checks, Visa, MasterCard, Discover and American Express. We do not accept postdated check.

SELF-PAY PATIENTS: Payment is due at the time of service

MEDICAID OR MEDICAID SUPPLEMENT COVERAGE: You must provide proof of coverage for the date you are receiving treatment. Please notify us of all other insurance coverage you have. If you are applying for Medicaid and have no other insurance, you are responsible for the payment for the services.

HEALTHY TEXAS WOMEN PROGRAM (WHP): You are responsible for the payment of services not covered.

MINORS: Parent(s) or Guardian(s) are responsible for payment of services provided to minors.

MEDICAL RECORD COPIES: $20.00 first 25 pages, $0.15 per additional page. Please allow 14 business days. Payment must be made before the copies are printed.

FMLA/ADMINISTRATIVE PAPPERWORK: We charge $15.00due at pick-up or before forms are faxed. Please allow 7 business days for completion.

Regardless of the source of payment for care provided, you have the right to request and receive itemized and detailed explanation of any billed service.

OUTSTANDING BALANCE POLICY:

It is our policy that past due account be sent two statements. If no payment or payment arrangement is not made on the account and attempts to contact you fail, your account will be sent to a collection agency, or attorney and may result in possible dismissal from the practice. You will be responsible for the collection cost, attorney fees and court cost.

You agree that our office will contact you by phone (home/cell), text, mail, email and via patient portal on account balances.

I have read and understand the financial policy of Palo Alto Women's health center. I agree to discuss all financial issues to the staff and the billing staff.

Patient's Name: _____ Signature: _____ Date: _____

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Office Policies

APPOINTMENTS

Our office prefers to see patients by appointment only. However same day appointments may be available depending on your condition. If you are an established patient please call when you need to be seen.

If you are unable to keep an appointment, please call our office as soon as possible preferable 24 hours or more before the appointment so that your appointment can be rescheduled and your time may be used for another patient.

The time allotted for each appointment depends on the nature of one's visit, so please give the staff enough information so she may assign the proper time and priority to your needs.

The receptionist will inform you if your doctor is delayed by a surgery or an emergency. Should you find you have been waiting for more than 30 minutes, please notify the staff. If you are more than 15 minutes late for your appointment we will make every effort to see you. At times you may have to reschedule your appointment.

Please bring a valid ID, insurance card, medication or medication list and referral to your appointment.

If you are transferring your care to our practice, we prefer to obtain your records before your appointment.

For your safety and cleanliness of the office no food and/or drinks allowed in waiting room/exam rooms.

CHILDREN IN THE OFFICE

Children are permitted IF there is another adult to care for the child during your appointment or the child is safely secured in a stroller, car seat, etc.

Our office will not be responsible for the care or safety of children. Keep all children seated and away from equipment and doors.

Please do not bring sick children to the office for the safety of our patients especially pregnant patients.

LABORATORY RESULTS

Our policy is to inform patients of abnormal results in a timely fashion. Please inform the office of any changes in your contact information. Lab results are usually available by 2 weeks after the test was performed. Please inquire accordingly.

PRESCRIPTIONS

Please call your Pharmacy who will then send a refill request to our office. If you need to call the office, please call during normal business hours so we can check your records to make sure a refill is the best course of treatment. You also should have the name and telephone number of your pharmacy available before your call. Please allow 2 business days for medication refill. We do not give new prescription is you have not been seen for a condition.

AFTER HOURS CALL / EMERGENCIES

If you are experiencing a serious or life-threatening emergency, dial 911.

If your condition is urgent and cannot wait till next business day, have the answering service contact the doctor at 210 922-3331

I have read and understand the office policy of Palo Alto Women's health center

Name: _____Signature:_____ Date: _____

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Acknowledgement of Review/Receipt of Notice of Privacy Practices

I acknowledge that PAWHC provided me with a written copy of his/her Notice of Privacy Practices.

I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.

Patient Signature_____ Date_____

Personal Representative Signature_____ Relationship to Patient_____

PHI DISCLOSURE TO FAMILY MEMBERS

You may authorize us to contact a family member regarding your medical care or financial matters. Check all that apply:

Name: _____ Relationship to Patient: _____

Telephone: _____Email:_____

Types of Information:

□Appointment Reminders □Results (lab test, X-Ray, etc.) □ Financial □ other_____

Okay to contact via: □Telephone □Leave Voice Mail □other: _____

Patient Signature_____ Date_____

Personal Representative Signature_____ Relationship to Patient_____